GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Georgia Medicaid/PeachCare for Kids™

**Provider Billing Manual
UB-04**

November 2010

Table of Contents

Appendix C   Miscellaneous Forms and Attachments 93

Appendix D   Attachment Codes...113

Glossary 115

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1 Introduction

1.1 Medicaid Overview

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments, including the District of Columbia and the Territories, to assist States in furnishing medical assistance to eligible needy persons. **Title XXI** of the Social Security Act PeachCare for Kids™ Program (PeachCare) was passed during the 1998 session of the Georgia General Assembly. Together, Medicaid/PeachCare for Kids™ provides the largest source of funding for medical and health-related services for individuals with low income and resources.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State:

- Establishes its own eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets the rate of payment for services
- Administers its own program

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, Medicaid eligibility and/or services within a State can change during the year.

The Department of Community Health (DCH) is managed by a nine-member board appointed by the Governor, and the Division of Medical Assistance (the Division) within DCH, administers Medicaid/PeachCare for Kids™ (O.C.G.A.§§31-5A-1 *et seq.*) Service delivery is accomplished through a variety of relationships with private and public entities and reimbursement is coordinated through DCH's third party administrator Fiscal Agent, HP Enterprise Services.

1.2 HP Enterprise Services in the State of Georgia

Effective November 1, 2010, HP Enterprise Services, will provide an efficient transition of fiscal agent responsibilities and a smooth transition from the current Georgia Medicaid Management Information System (GAMMIS) to the new GAMMIS interChange. InterChange is an HP Enterprise Services-developed GAMMIS that has been developed over years of successful implementations. InterChange is a Centers for Medicare and Medicaid Services (CMS)-certifiable, highly sophisticated, feature-rich system centered on a strong, Medicaid-specific relational data model. This design and supporting architecture deliver enhanced flexibility, scalability, and reliability.

1.3 Overview of Functions

DCH

Function:

Administration

Budget and Fiscal Control

Contract Administration and Monitoring

Program Policies and Procedures

Liaison with Federal Agencies

Facility Licensing Office of Regulatory Services (ORS)

HP Enterprise Services

Function:

Fee for Service (FFS) Claims Processing

Encounter Processing

Provider/Member Enrollment

Provider/Member Contact Center/Written Inquiries

Provider Training

TPL

Financing and Banking

PeachCare for Kids™

Function

Enrollment for PeachCare

Eligibility Determination

GMCF

Function:

Pre-Certification

Medical- Prior Approval (PA)

Outlier Review

Out-of-State Services

Pre-Payment Review

MAXIMUS

Function:

CMO Member Enrollment

DHS/DFCS/SSA

Function:

Eligibility Determination

Prior Approval

2 Purpose

2.1 Overview

The UB-04 Billing Manual was created to help providers accurately complete and file a Medicaid/PeachCare for Kids™ UB-04 claim form. This manual assists you by offering billing instructions, sample UB-04 forms, and contact information for services beyond the scope of this manual.

2.2 The Purpose of this Manual

This manual contains basic billing information concerning Georgia's Medicaid/PeachCare for Kids™ program and is intended for use by all participating providers. This manual encompasses the terms and conditions for receipt of reimbursement.

We urge you and your office team to familiarize yourself with the contents of this manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning eligibility and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

This manual should be used in conjunction with the following Georgia Medicaid policy manuals:

- Part I Policies and Procedures for Medicaid/PeachCare for Kids™ which contains basic information concerning the Georgia Medicaid Program along with the terms and conditions for receipt of reimbursement.

- Part II Policies and Procedures specific to the services you provide. This manual explains covered services, their limitations, and who is eligible to receive the service.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (the Department), Division of Medical Assistance (Division) policy. When such amendments are made, they will be posted at the HP Enterprise Services Web Portal at www.mmis.georgia.gov which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual provisions as of their effective dates.

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3 Member Eligibility

3.1 Overview

The DCH establishes eligibility criteria for Medicaid/PeachCare for Kids™ benefits based upon federal regulations. For detailed member eligibility information, please see the applicable DCH Provider Policy and Procedures Manual.

3.2 How to Verify Member Eligibility

It is the responsibility of the provider to verify Medicaid/PeachCare for Kids™ eligibility on each date of service. Members are issued Medicaid/PeachCare for Kids™ identification cards (See below) which should be presented on each date of service. Providers must verify eligibility by accessing the HP Enterprise Services Web Portal at www.mmis.georgia.gov, or using the IVRS at 1-800-766-4456. Both the Web Portal and IVRS are available 24 hours per day, seven days a week. Member eligibility verification can be processed through the Web Portal either individually or in batch by submitting a Health Insurance Portability and Accountability Act (HIPAA) compliant transaction. Providers may also submit a written request for eligibility verification to:

HP Enterprise Services

P.O. Box 105200

Tucker, Georgia 30084-5200

3.3 Valid types of Member Identification

3.3.1 Medicaid/PeachCare for Kids™ Identification Card

This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids™ Plans.

Verify eligibility at www.mmis.georgia.gov

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If member is enrolled in a managed care plan, contact that plan for specific claim filing and prior authorization information.

Payor: For Non-Managed Care Members
Customer Service: 1-800-766-4456 (Toll Free)

HP Enterprise Services	SXC, Inc.	**Mail Drug Claims to:**
Member: Box 105200	Rx BIN-001553	SXC Health Solutions, Inc.
Provider: Box 105201	Rx PCN-GAM	P.O. Box 3214
Tucker, GA 30085	SXC Rx Prior Auth	Lisle, IL 60532-8214
Prior Authorization:	1-866-525-5827	Rx Provider Help Line
1455 Lincoln Parkway, Suite 800		1-866-525-5826
Atlanta, GA 30346		

This card is for identification purposes only, and does not automatically guarantee eligibility for benefits and is non-transferable.

Figure 1: Front and Back of the Medicaid/PeachCare for Kids™ Identification Card

3.3.2 Supplemental Security Income Notification Letter

This letter is issued by the DCH to the member. If the date of service falls within the specified months, the letter serves to verify the member's eligibility. Use the name and Medicaid number designated in the letter when completing the claim. If submitting the claim using paper, attach a copy of the letter to the claim. If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to HP Enterprise Services at 1-866-483-1044 (see form in Appendix C.10). When filing paper claims send the letter with your claim to:

HP Enterprise Services

P.O. Box 105204

Tucker, Georgia 30084-5204

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

APPROVAL LETTER
Date: July 10, 2010

Glory Days
1111 Peace St
Tucker, GA 33300

NOTICE OF MEDICAID STATUS

You are eligible for Medicaid for the following months: **07,2010**   , ongoing.

You are eligible for Medicaid because you were paid and continue to be paid Supplemental Security Income (SSI) through the Social Security Administration. Medicaid and SSI go together.

This notice is your only proof of eligibility for these months. Take this notice to your medical care providers as soon as possible. Ask your providers to file a claim with us if you have unpaid medical bills for any of these months.

Information about the Medicaid Card

Your plastic Medicaid card will be mailed to you in the next two weeks. Your Medicaid card is not your proof of eligibility. Carry the card with you at all times. Your medical care provider uses the card to verify your Medicaid eligibility. No one is to use the Medicaid card but the member named as eligible on the front of the card. Your Medicaid card is mailed to you at the address you give the Social Security Administration. If you move, you are to report your address change to your local Social Security office as soon as possible. If you want information about Medicaid, call XXX-XXX-XXXX in Atlanta or 1-XXX-XXX-XXXX (toll free) and ask for the booklet, UNDERSTANDING MEDICAID, to be mailed to you. You may also call your local county Department of Family and Children Services for this booklet.

Medical Care Under Medicaid

Medicaid pays for most medical care that you will need. If you want Medicaid to pay for your medical care, you must use a medical care provider who agrees to accept your Medicaid each time you go for medical care. Take your Medicaid card with you each time you go for medical care. You may need certain medical care that is not paid by Medicaid or requires prior approval before Medicaid agrees to pay. This information is in the booklet, UNDERSTANDING MEDICAID. Some of the information is on the back of your Medicaid card. You also may call XXX-XXX-XXXX in Atlanta or 1-XXX-XXX-XXXX (toll free) if you have questions about medical care that requires prior approval.

Other Information

If you have unpaid medical bills incurred immediately prior to applying for or receiving SSI, you may be eligible for Medicaid to pay for these unpaid medical bills. Contact your local county Department of Family and Children Services to apply for Prior Months Medicaid. If you already have MEDICARE insurance through the Social Security Administration, then Medicaid will pay your MEDICARE cost share. MEDICARE cost share (out—of—pocket expenses) includes the monthly insurance premium, the yearly deductible and the coinsurance charges.

Note: If you ever refuse Medicare insurance because you did not want to pay the monthly premium, then you may now want to apply for Medicare. Medicaid will pay the monthly premium for you under the QMB program. However, Medicaid will pay for your hospital and medical expenses even if you do not have Medicare. You would apply for QMB at your local county Department of Family and Children Services.

If you are pregnant or breastfeeding a child or if you have a child under age 5, you may apply for a supplemental food program know as WIC (women, infants and children)-. You may apply for WIC at your county public health office, at Southside, Inc. (Atlanta) or at Grady Hospital (Atlanta).

Figure 2: Supplemental Security Income Notification Letter

3.3.3 Certification of Supplemental Security Income Eligibility Letter

The Social Security Administration issues this letter. If the Date of Service is included within the specified month, this letter serves as verification of the member's eligibility. Use the name and Medicaid number designated on the letter when completing the claim, and keep a copy of the letter for your records. The Medicaid ID number can be used to verify eligibility. This information will also appear on your Remittance Advice (RA). If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to HP Enterprise Services at 1-866-483-1044 (see form in Appendix C.11). When filing paper claims send the letter with your claim to:

HP Enterprise Services

P.O. Box 105204

Tucker, Georgia 30084-5204

CERTIFICATION OF SSI ELIGIBILITY

MEMORANDUM

TO: _____ County Office
        Department of Family and Children's Services

FM: Social Security Adm.
        Bx 938
        Gainesville, GA 30503

RE: Verification of SSI Eligibility for Establishing Medical
        Assistance on an Emergency Basis

The individual identified below is in emergency need of medical assistance and is eligible
for Supplemental Security Income (SSI) cash payments. Please use the verification
provided below to establish medical assistance.

Name of Eligible Individual: _____

Address: _____

Social Security No.: _____ Date of Birth: _____ Sex: _____

Social Security Claim No. (if different): _____

Aged _____ Blind _____ Disabled _____ Date of Application: _____

This individual is SSI eligible and receiving SSI payments (effective date) _____
through the end of _____.

Are there any months of ineligibility for SSI between the two dates given above?
Yes ___ No ___

If not, please identify each month/year the individual was not residing in Georgia.
_____

Has this individual either refused to assign to the State his/here rights to third party
resources or agreed to assign to the State these right but failed to cooperate in providing
information about his/her third party resources?
Yes ___ No ___

Prepared by: _____ Title: _____

Figure 3: Certification of Supplemental Security Income Eligibility Letter

3.3.4 Temporary Medicaid Certification Notification (Form 962)

This letter is generated by the local Department of Family and Children Services (DFCS) office in response to a member's request for eligibility verification. Use the name and Medicaid number as it appears on this letter when completing the claim form, and keep a copy of the letter for your records. The Medicaid ID number can be used to verify eligibility. If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to HP Enterprise Services at 1-866-483-1044 (see form in Appendix C.11). When filing paper claims send the letter with your claim to:

HP Enterprise Services

P.O. Box 105204

Tucker, Georgia 30084-5204

Georgia Department of Human Resources
Certification of Medicaid Eligibility

Mail to: HP Enterprise Services
P.O. Box 105200
Tucker, GA 30085

_____County DFCS

County Code: _____

GHP Action Needed: ☐ Add   ☐ Correction

Case Name: _____

Address: _____

_____

AU #: _____

Eligibility Status: ☐ Approved Ongoing
                   ☐ Denied Ongoing

BASIS OF ISSUANCE	REASON FOR ISSUANCE
☐ Final Disposition: _____ (date) ☐ RAPS Approval: _____ (date) ☐ SSI Cert Letter: _____ (date) ☐ NH/Waiver Authorization: _____ (date) ☐ Web Portal/IVR: _____ (elig date) ☐ Manually Updated on MHN: _____ CIC Contact: _____	☐ Newly Eligible/DFCS ☐ Newly Eligible/SSI ☐ Medicaid Card Lost/Stolen ☐ Non Receipt of Medicaid Card ☐ Verification of Historical Months

This is to certify that the following individual(s) is eligible for medical assistance in the month(s) listed below:

Name (Last, First, MI)	DOB	Race	Gender	MHN Aid Code	SSN	Client ID or MHN ID	Eff Date	End Date

MN Cases: First Day Liability: _____   Form(s) 400 Required: Y N   Pharmacy is Break-Even Bill: Y N

Comments: _____

DFCS Certification of Medicaid Eligibility:

_____ _____ _____
(Print or Type Caseworker Name)   (Caseworker Signature)   (Telephone Number)

To be signed ONLY after months are active on SUCCESS, added to/active on MHN or SSI Cert Letter is in hand.

Form 962 (Rev. 07/03)   White Copy: Member/Provider   Yellow Copy: GHP   Pink Copy: Case Record

Figure 4: Temporary Medicaid Certification Notification (Form 962)

3.3.5 Certification of Retroactive Medicaid Eligibility (Form 964)

Two styles of retroactive certification forms are issued by the county DFCS to members. One style of the retroactive certification form is completed by hand (see figure 5). The second type is computer generated (see figure 6). A member may present either of the two forms as verification of eligibility for the month(s) shown on the form. Use the name and Medicaid number from the retroactive certification form when completing a claim for services provided during the Month(s)/Day/Year(s) of eligibility shown on the retroactive certification form. When filing your claim, keep a copy of the form for your records. The Medicaid ID number can be used to verify eligibility. If a copy of this letter is required with a claim that is submitted electronically or using the Web Portal, send it with the Electronic Attachment Form and fax it to HP Enterprise Services at 1-866-483-1044 (see form in Appendix C.11). When filing paper claims send the letter with your claim to:

HP Enterprise Services

P.O. Box 105204

Tucker, Georgia 30084-5204

The following form can be issued when the member needs immediate care or is applying onsite for Medicaid.

Figure 5: Certification of Retroactive Medicaid Eligibility (Form 964)

The following is an example of the computer generated retroactive verification form. This form is issued by the county DFCS and can be used retroactively.

```
Client Number: 734003069        01-000041          PAGE 5
_____

0062 - CERTIFICATION OF MEDICAID ELIGIBILITY

MADISON County Department of Family and Children Services

FINAL DISPOSITION DATE:   10 01 98

(Providers: DO NOT submit claims until two weeks after the above
date unless a copy of this form is attached to the claim.)

 Payee Name: LAW , CINDY                   AU  ID:  188501907

Payee Address:    123 MAIN ST
                       DANIELSVILLE GA   30633-4207

This is to certify that the following individual (s) is eligible
for Medical Assistance (Medicaid) for the month (s) listed below:

LIST OF ELIGIBLE PERSONS:
    ....... Name _____

 Last       First    M    SEX      MA ID             SSN            DOB
 LAW        CINDY          F     734003069P       789-78-9489     08 17 61
                      Eligible 10 01 98 thru 10 31 98
                      Eligible 09 01 98 thru 09-30 98
 LAW        ROBERT         M     993002112P       456-78-9747     08 16 95
                      Eligible 10/01/98 thru 10 31 98
                      Eligible 09 01 98 thru 09 30 98
```

Figure 6: Certification of Retroactive Medicaid Eligibility (Computer Generated)

3.3.6 Presumptive Eligibility for Pregnant Women Worksheet (DMA-632)

The qualified provider issues the DMA-632 to the presumptively eligible member. The DMA-632 serves as the member's temporary identification card and may be used as confirmation of presumptive eligibility for the Medicaid program as of the indicated date. The qualified provider should print the computer generated form, produced using the Web Portal (see figure 7) and give it to the member. The member receives the green copy of the worksheet if hand generated. Either the computer generated or green copy serves as the first month's Medicaid certification. A member can use the form until the permanent member identification card arrives.

Note: Presumptive eligibility covers all Medicaid services except inpatient hospital services and delivery procedures.

Figure 7: Presumptive Eligibility for Pregnant Women Worksheet (DMA-632)

Figure 8: Presumptive Eligibility for Pregnant Women (Computer Generated)

Note: Presumptive eligibility covers all Medicaid services *except* inpatient hospital services and delivery procedures.

3.3.7 Presumptive Eligibility for Women's Health Medicaid Worksheet (DMA-632W)

The Women's Health Medicaid program is for women who have been through special screenings and have a diagnosis of breast or cervical cancer. The qualified provider issues the DMA-632W worksheet, which is either hand-written or computer generated, to the presumptively eligible member. This worksheet serves as the first month's Medicaid certification (See figure 9 for hand-written and figure 10 for an example of the computer generated form.)

Figure 9: Presumptive Eligibility for Women's Health Medicaid Worksheet (DMA-632W)

Figure 10: Presumptive Eligibility for Women's Health Medicaid (Computer Generated)

3.3.8 Newborn Eligibility (DMA-550)

The qualified provider issues the DMA-550 worksheet to a newborn's mother. This worksheet serves as the first month's Medicaid certification. There is also a computer generated DMA-550 worksheet that is produced using the Web Portal. (See figure 11 for hand-written and figure 12 for an example of the computer generated form.)

Note: The Web Portal newborn eligibility site limits qualified providers to entering only one newborn. The Web Portal should not be used for submitting newborn eligibility for multiple births. Qualified providers must submit the newborn eligibility form directly to HP Enterprise Services to have the additional newborn information and eligibility added.

NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please mail completed form to

GHP
P.O. Box 105209
Tucker, GA. 30085-5209

NEWBORN MEDICAID ID NUMBER
Certifying provider must contact GHP
to obtain a newborn I.D.

NEWBORN'S NAME

First — MI — Last — Suffix

DATE OF BIRTH

SEX Male ☐ Female ☐

Mother's Medicaid ID No.

Mother's Social Security No.

YES ☐ NO ☐

Is the mother a U.S. Citizen?

MOTHERS NAME

First Name — MI — Last

MAILING ADDRESS

Number and street — City

State — Zip — County — Telephone Number

Date of Request — Parent/Relative Signature

COMPLETED BY
Please Print

TITLE
Please Print

PROVIDER NAME
Please Print

TELEPHONE

PROVIDER SIGNATURE
By signing, I certify to the best of my knowledge that the information above is verified and accurate

DATE COMPLETED

PROVIDER NO.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

DMA-550 REV. (07/10)

Figure 11: Newborn Eligibility Worksheet (DMA-550)

Figure 12: Newborn Eligibility (Computer Generated)

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4 Completing the UB-04 Claim Form

4.1 Overview

Medicaid cannot make payments to a provider who performs services to a Medicaid member unless the provider submits a claim for reimbursement.

Federal regulations prohibit providers from charging members, the Georgia Medicaid Agency, or HP Enterprise Services a fee for completing or filing Medicaid claim forms. The cost of filing a claim is considered part of the usual and customary charges for all members.

This chapter provides basic information for filing claims. The information is specific to providers who can bill on the UB-04 form; it is intended to give all providers an understanding of the various methods for claims submission and instructions on completing the claim form. Once you understand the information in this section, you will need to refer to your specific provider type in the Part II Policy and Procedures Manual chapter that details specific billing instructions for your services.

This chapter describes how to complete and submit the UB-04 claim form for payment from the Georgia Medicaid Program through HP Enterprise Services.

4.2 Providers Responsibility

Georgia Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Georgia Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This manual contains the claims processing requirements for Georgia Medicaid, including the requirements necessary to comply with HIPAA.

4.3 Providers Who Are Required to Bill on the UB-04 Claim Form

The following providers, **must bill using the UB-04 claim form** to receive Medicaid reimbursement:

- Hospitals (inpatient/outpatient services)

- Hospice

- Nursing home

- Swing bed

- Ambulatory surgical center/birthing centers

- Hospital-based rural health centers

- Dialysis facilities (that are billing the technical component)

- Intermediate care facility for mentally retarded (ICF/MR)

- Ambulance services (Medicare crossover only)

- Psychiatric residential treatment facility (PRTF)

4.4 Time Limit for Submission of a Claim Form

4.4.1 Timely Claim Submission

Medicaid providers must submit claims within six months from the date of service. DCH urges providers to submit claims immediately after providing services so that the claim can be corrected if necessary, and then resubmitted before the filing deadline. See chapter 200 of the Part I Policy and Procedures Manual for detailed information on Timely Submission.

4.4.2 Clean Claim

In order for a claim to be paid, it must be a clean claim. A clean claim means a claim that:

- Has been completed properly according to Medicaid billing guidelines on the UB-04 claim form with red dropout ink.

- Is accompanied by all necessary documentation required by federal law, state law, or state administrative rule for payment.

- Can be processed and adjudicated without obtaining additional information from the provider or from a third party.

4.4.3 Six-Month Filing Limit

A clean claim for services rendered must be received by HP Enterprise Services no later than six months from the date of service.

4.4.4 Out-Of-State Claims

Claims submitted by an out-of-state provider must be received by HP Enterprise Services no later than 12 months from the date of service to be considered for payment.

Out-of-state providers must comply with all other Georgia Medicaid claim filing time limits.

4.4.5 Date Received Determined

The date of receipt for a paper claim is determined by the actual date of receipt in the HP Enterprise Services mail room, not the mail date or post mark date. An ICN is assigned to each paper claim received. This 13-digit ICN contains the region code, date of receipt, and a sequence number. The format is RRYYDDDSSSSSS. The date electronically coded on the provider's electronic transmission by HP Enterprise Services is the recorded date of receipt for an electronically submitted claim.

4.4.6 Medicare/Medicaid Crossover Claims

Claims in this category must be received within 24 months from the month of service at the address used for regular claims submission. A provider must wait at least 45 days from the date of payment by Medicare and not automatically sent by the Medicare Carrier or Intermediary to submit a Medicare crossover claim.

4.4.7 Third Party Payer or Insurance Claims

Claims originally filed timely with a third party carrier, but were denied or paid insufficiently, must be billed to Medicaid within three months from the date of the denial or payment, but never more than 12 months from the month of service. Claims filed timely with a third party carrier, but did not generate a response from the carrier, despite all reasonable actions taken, may be filed with Medicaid using the COB Notification Form attachment, (DMA-410), indicating no response was received.

Note: Please refer to the Part I Policy and Procedures Manual and the Medicaid Secondary User Guide for detail COB requirements.

4.5 How to Complete the UB-04 Claim Form

4.6 UB-04 Claim Form Field Description

The following table provides a brief description of the fields located on the UB-04 claim form. The alphanumeric data located in the **Field locator** column identifies the location of the field on the UB-04 claim form. Data is entered in this area on the form. The data located in the **Field Name** column identifies and names the field for the given location. The alpha character shown in the **Required Field** denotes the following:

- R - Required

- C - Conditionally required/if applicable

- RI - Required inpatient only

- RO - Required outpatient only

- Blank - Not required

The information located under the **Guidelines** area explains what you should enter in the given field.

This section contains an illustration of the UB-04 claim form, step-by-step instructions, and a sample of a completed form.

Field Locator	Field Name	Required Field	Guidelines
1	Provider Name, Address, Phone number and Fax number	R	Enter the provider name, address, phone number, and fax number.
2	Pay-to Name, Pay-to Address, Pay-to city, State	C	Report only when the pay-to name and address is different than the Billing Provider in Field Locator 1.
3a	Patient Control Number	C	Enter the member's unique alpha-numeric number assigned by the provider.
3b	Medical Record Number	C	Use the patient's medical record number printed on the remittance voucher.
4	Type of Bill	R	Enter the appropriate digit code and frequency for bill type. Please refer to your program Part II Policy and Procedures Manual for the valid bill types.
5	Federal Tax Number	R	Enter the provider's federal identification number.

Field Locator	Field Name	Required Field	Guidelines
6	Statement Covers Period- From/Through	R	Enter the dates of service covered by claim (from - through date).
7	Unlabeled	Blank	
8	Patient Name	R	Enter the patient's last name, first name and if any, middle initial.
9	Patient Address	R	Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, state, and ZIP Code.
10	Patient Birth Date	R	Enter the member's date of birth (use MM/DD/YY format).
11	Patient Sex	R	Enter the sex of the patient as "M" for male or "F" for female.
12	Admission/Start of Care Date	RI	Enter the member's date of admission.
13	Admission Hour	R	Enter the member's time of admission.
14	Type of Admission/Visit	RI	Enter the code indicating the priority of this admission.
15	Source of Admission	RI	Enter the member's source of admission.
16	Discharge Hour	RI	Enter the hour (00-23) that the patient was discharged from inpatient care if there is a discharge code in field 17.
17	Patient Discharge Status	RI	Enter the member's status at discharge.
18 – 28	Condition Codes	RI	Enter the condition code(s), if applicable.
29	Accident State	C	When medical services resulted from an auto accident, enter the state code for the state in which the accident occurred, for example, FL, GA, etc.
30	Unlabeled	Blank	
31 – 34	Occurrence	RI	Enter occurrence code(s) and

Field Locator	Field Name	Required Field	Guidelines
	Code/Date		dates, if applicable.
35 - 36	Occurrence Span Code/From/Through	RI	Enter occurrence code(s) and associated beginning and end dates.
37	Unlabeled	Blank	
38	Responsible Party Name/Address	C	Enter name and address of responsible party, if applicable.
39 - 41	Value Code - Code/Value Code - Amount	C	Enter valid value code 80 (covered days) and 81 for (non-covered days) and the appropriate number adjacent to each.
42	Revenue Code	R	Enter appropriate revenue code.
43	Revenue Code Description	C	Using one line for each, enter description of service(s) or procedure(s) provided.
43	Page ___ of ____ (Line 23)	R - on all pages	Enter the number of claims.
44	CPT/HCPCS/Rates/HIPPS Rate Codes	R – on all pages	Enter appropriate Current Procedural Terminology (CPT-4) or 11-digit National Drug Code (NDC) number. Effective for dates of service on and after January 1, 2007, use NDC numbers rather than HCPCS codes to bill/report injectable drugs.
45	Service Date	R	Enter the line item service date.
45	Creation Date (Line 23)	RO	Service Date Required on outpatient claims. Lines 1 – 22: On each line, enter the date of service. Line 23: On each page, enter the date the bill was created or prepared for submission in MMDDYY format.
46	Service Units	R	Enter the number of times the procedure, for which you are billing, was performed.
47	Total Charges	R	Enter the total amount of charges for service(s) / procedure(s) performed.

Field Locator	Field Name	Required Field	Guidelines
48	Non-Covered Charges	C	Enter third-party payment, if applicable.
49	Unlabeled	Blank	
50 A,B,C	Payer Name: Primary	R	Enter payers in order of benefit determination (A=Primary, B=Secondary, C=Tertiary).
	Payer Name: Secondary	C	
	Payer Name: Tertiary	C	
51 A,B,C	Health Plan ID	Blank	
52 A,B,C	Release of Information	C	Indicate whether the patient or patient's legal representative has signed a statement permitting the provider to release data to other organizations.
53 A,B,C	Assignment of Benefits	Blank	
54 A,B,C	Prior Payments	C	Other insurance and/or Medicare payments associated with payers in field locator 50.
55 A,B,C.	Estimate Amount Due	C	Enter the estimated amount due from Medicaid, generally equals the patient liability.
56	National Provider ID	R	Enter the NPI number (required on paper claim submission).
57 A,B,C	Other Provider ID	C	Enter Medicaid provider number (required on paper claim submission).
58 A,B,C	Insured's Name	C	Enter the last name, first name and middle initial of the insured, if applicable, for each payer listed in field locator 50.
59 A,B,C	Patient's Relationship to Insured	C	Enter relationship of the patient to the identified insurer, if applicable, for each payer listed in field locator 50.
60	Insured's Unique ID	R	Enter Medicaid member's identification number on the

Field Locator	Field Name	Required Field	Guidelines
A,B,C			Medicaid card or the approval letter (for the member being treated) to the line associated with Medicaid in field locator 50. Enter appropriate ID numbers for any other payers identified in field locator 50.
61	Insurance Group Name	C	Enter other payer's group/employer name.
62	Insurance Group Number	C	Enter group number, if applicable, for each coverage listed in field locator 50.
63	Treatment Authorization Code(s)	C	Enter PA number, if applicable. The claim must be split if more than one PA applies.
64	Document Control Number	C	Enter the control number assigned to the original bill by the health plan or the health plan fiscal agent.
65	Employer Name	C	Enter name, if applicable, for each payer listed in field locator 50.
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	R	Enter the version of International Classification of Diseases (ICD) reported. GA Medicaid does not except ICD-10 codes; only ICD-9 codes.
67	Principle Diagnosis Code	R	Enter the appropriate ICD-9 diagnosis code.
67 A - Q	Other Diagnosis Codes	C	Enter the appropriate ICD-9 diagnosis codes, if applicable.
68	Unlabelled	Blank	
69	Admitting Diagnosis Code	C	Enter the appropriate ICD-9 diagnosis code describing the member's diagnosis at the time of, if applicable.
70 A-C	Patient Reason for Visit Code	RO	Enter the appropriate ICD-9 code for all unscheduled outpatient visits.
71	Prospective Payment System Code	Blank	
72	External Cause of	Blank	

Field Locator	Field Name	Required Field	Guidelines
	Injury Code		
73	Not Used	Blank	
74	Principal Procedure Code/Date	R	Enter the appropriate ICD-9 Surgical procedure code and date, if applicable.
74 A-E	Other Procedure Codes and Dates	R	Enter the appropriate ICD-9 Surgical procedure code(s)and dates, if applicable.
75	Not Used	Blank	
76	Attending Provider Name and Identifiers (including NPI)	R	Enter the attending physician Universal Provider Identification Number (UPIN), National Provider Identification (NPI), or Medicaid provider number, if applicable.
77	Operating Provider Name and Identifier (including NPI)	C	Enter the name and identification number of the individual with the primary responsibility for performing a surgical procedure.
78 & 79	Other Provider Name and Identifiers (including NPI)	C	Enter the name and ID number of the individual corresponding to the provider type qualifiers: DN: Referring Provider ZZ: Other Operating MD 82: Rendering Provider. Secondary ID qualifiers: OB: State License number 1G: Provider UPIN G2: Provider Commercial number
80	Remarks	Blank	
81 a-d	Code-Code	CC	81.a If a NPI is entered in field locator 56 and the provider's NPI is mapped to a taxonomy code that is needed to identify the provider in the Medicaid claims processing system, the provider must enter qualifier code B3 and the taxonomy code in this field locator.

Field Locator	Field Name	Required Field	Guidelines
	Qual/Code/Value		81.b-d Enter these codes when additional fields are needed in field locators 31-34 Occurrences, 35-36 Occurrences Span, and 39-41 Value Code.
			Valid Qualifiers are:
			A1 - condition code
			A2 - occurrence code
			A3 - occurrence span code
			A4 - value code
			AC - attachment
			B3 - taxonomy
			RR - radiology report

Sample of a Completed UB-04 Claim Form

4.6.1 Claims Submission Checklist

Use the following checklist before submitting a paper claim to HP Enterprise Services for reimbursement.

- Is the form typed or printed in black ink?

- Is the form legible?

- Were instructions in the manual followed? Some items are not self-explanatory or may be used for other purposes.

- Are the provider's name and number entered?

- Is the claim signed and dated? Unsigned claims will be returned unprocessed.

- Are attachments required? Claims cannot be paid without the required attachments.

- Is the PA number included in field locator 63 on the UB-04 for services that require PA from Medicaid? Without this number, payment will be denied.

- Is the P.O. Box number for submitting the claim correct?
  Note: See Where to Send Claim Forms in section 4.6.3 for a complete list of addresses to submit claims and other forms.

If your questions are not answered in this manual, call HP Enterprise Services Provider Services Contact Center at 1-800-766-4456 and select option 0. The Provider Services Contact Center is available Monday – Friday, 7:00 a.m. to 7:00 p.m. Eastern Standard Time.

4.6.2 Claims Mailing Checklist

The following checklist may be used when mailing claims to HP Enterprise Services for reimbursement.

- Enclose only one claim type per envelope, for example, clean UB-04, adjustment UB-04, or void UB-04. Claims and adjustment requests should be sent separately, because they are processed separately at HP Enterprise Services.

- The claims envelope should be addressed to the correct P.O. Box and corresponding nine-digit ZIP code specific to the claim type being mailed. Printed addresses speed up post office processing.

- Claims mailed in a large envelope or flat should be marked first class and paid for as first class postage. If first class is not specified, the post office will send large envelopes as third class mail. This will delay delivery of claims to HP Enterprise Services.

4.6.3 Where to Send Claim Forms

Claim Type	Address
Original or Resubmitted UB-04	UB-04 Claims P.O. Box 105204 Tucker, Georgia 30084-5204
UB-04 Crossover	UB-04 Crossover Claims P.O. Box 105203 Tucker, Georgia 30084-5203

4.7 Electronic Claim Submission

4.7.1 Introduction

Submitting Medicaid claims using electronic media offers the advantage of speed and accuracy in processing. Providers may submit electronic claims themselves or choose a trading partner or clearinghouse that offers electronic claim submission services.

4.7.2 Benefits

The benefits of electronic claims submission include:

1.   Increased speed of claims payments; seven days in some cases

2.   Correct data entry errors immediately, avoiding mailing time and costs

3.   Eliminate the cost and inconvenience of claims paperwork

4.   Reduce office space required for storing claim forms, envelopes, and so on

5.   Decrease clerical labor costs

6.   Automate the office for a more efficient operation

4.7.3 How to Participate in Electronic Claims Submission

In order to submit electronic claims, a provider and/or their representative/billing agent must be authorized. The authorization process requires the submission of the Electronic Data Interchange Agreement Form, issuance of a trading partner ID, and testing to ensure the trading partner can accurately submit transactions.

The EDI Services team is available each weekday (excluding state holidays), Monday through Friday from 8:00 a.m. - 5:00 p.m., Eastern Standard Time at 1-877-261-8785 or using e-mail at ediservices.gammis@hp.com

4.7.4 Free Software and Electronic Claims Submissions Options

DCH strongly encourages electronic submission of claims and most other transactions.

HP Enterprise Services supports several types of data transport depending upon the provider, trading partner, or billing agent's needs. Providers and their

representatives submit and receive data using: Web Portal, Provider Electronic Solutions (PES) software, Remote Access Server (RAS),diskette/CD-ROM/tape, DVD, Secure File Transfer Protocol (SFTP), and Value Added Network (VAN) for interactive transactions.

The following sections provide an overview for each of the EDI submission methods.

4.8 Web Portal

Data is transmitted using the secure Web Portal. Submission options are Direct Data Entry (DDE) and Batch. The GAMMIS Web Portal (as a single gateway) is an important tool providing general and program specific information and links to other programs, applications, related agencies and resources. The Web Portal has both secure and non-secure areas.

The Web Portal is available to customers 24 hours per day, seven days per week (except during pre-scheduled system maintenance). To access the Web Portal, visit www.mmis.georgia.gov. For more information concerning Web Portal usage and registration, see the Provider Web Portal Navigational Manual for additional details, which is located on our website www.mmis.georgia.gov on the Provider Manuals page found under the Provider Information menu.

The homepage displays:

4.8.1 Web Portal Reference Updates

Reference updates or changes regarding EDI issues or compliance edits are posted to the Web Portal by the EDI Services or EDI Systems team to alert all providers, trading partners, and third-parties of any issues that may impact electronic production of claims and other critical system maintenance issues, and future enhancements (for example, implementation of International Classification of Diseases-10 (10th revision)-Clinical Modification (ICD-10CM) diagnosis and procedure codes).

4.8.2 Web Portal Password Management

Step 1: Access the public Web Portal at: www.mmis.georgia.gov.

Step 2: Click the "Login" button on the public Web Portal Home page.

Step 3: Enter the **Username** and **Password** for the registered account you wish to act as and click "Sign In."
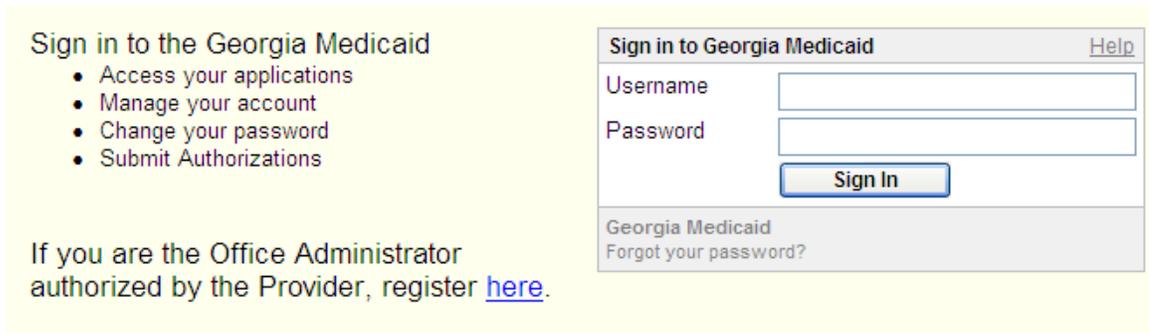
Please Note: If the password has been forgotten or has already expired, click the "Forgot your password?" link on the log in page and enter the e-mail address and user name created during the registration process. If the username has been misplaced, please navigate to the pubic Web Portal (www.mmis.georgia.gov) and click the Provider Information menu for methods on contacting EDI Services for further assistance.
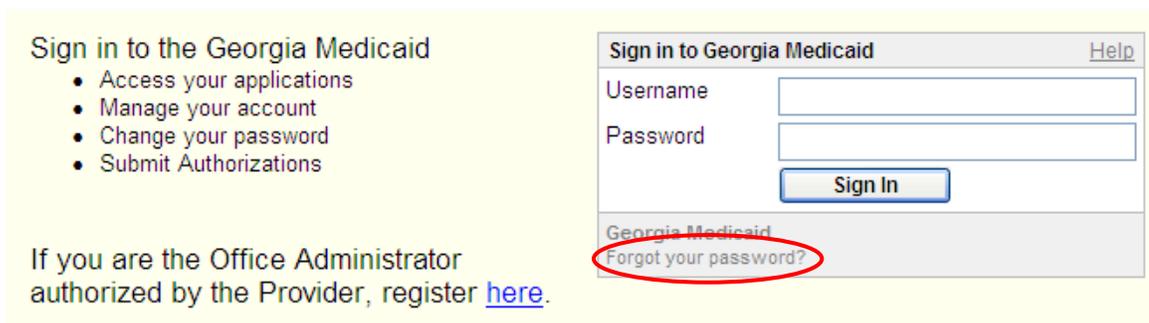
Step 4: If the log in was successful, click "MEUPS Account Management."

Step 5: Click "Change Password."

Step 6: Complete the fields displayed and click "Change Password." Make sure your new password conforms to the format indicated on the screen.

4.8.3 Web Portal Support

In addition to providing EDI support, the EDI Services team will also assist with all Web Portal technical support questions including all Web Portal problems that members, providers, and provider office administrators/billing agents may have accessing the Web Portal, and registering for the Web Portal.

Note: The Provider Services Contact Center assists all providers with non-EDI and non-technical issues regarding the Web Portal, including where to locate specific information, forms, and provider manuals.

The Member Services Contact Center assists all members with non-EDI and non-technical issues regarding the Web Portal, including Web Portal password resets, where to locate pamphlets, forms, and coverage limitations.

4.8.4 Direct Data Entry (DDE) Transmissions Using the Web Portal

Direct Data Entry (DDE) allows providers to submit individual transactions one transaction at a time, with no limitations on the number of transactions that can be submitted using the Web Portal.

Note: DDE is not available for NCPDP (Encounters).

4.8.5 Upload Batch Transmissions Using the Web Portal

A trading partner has the option to upload HIPAA based transactions such as a batch of claims or eligibility request or non-HIPAA transactions via the Web Portal for processing in the MMIS. All claims must be in the HIPAA compliant format (i.e. X12 837-Professional, 837-Institutional, or 837-Dental). A batch may contain one claim transaction or many.

Trading partners log on to the secure Web Portal, navigate to the Trade Files menu option, and upload a file. The following screen displays:

The file is validated against the Georgia Medicaid Companion Guides and the user receives one or a combination of three different acceptance and rejection reports, TA1, 997, 824, or 277U.

1. TA1 - The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

2. 997 – The X12N 997 contains accept or reject information. If the file contained syntactical errors, the segments and elements where the error

occurred are reported on the rejected 997. If no errors are found, a 997 transaction is sent to acknowledge receipt and acceptance of the transaction.

3. 824 - The X12N 824 contains accept or reject information for X12N 837 input files. It will report errors that are outside the scope of the X12N 997. If the input file contained errors, the segments and data elements where the error occurred are reported on the 824. The 824 will have an action code of "RU" if the incoming file was partially accepted, "U" if the incoming file was entirely rejected or "WQ" if the incoming file was entirely accepted.

4. 277U – The X12N 277U is returned for all suspended claims. In addition, the 277U is used to communicate claims where a provider record cannot be determined (primarily related to NPI mapping activities).

If the file passes compliance, it is sent to GAMMIS for processing.

Notes regarding file specifications:

1. EDI allows upload and download of zip files. However, only one file per zip is allowed.

2. EDI does not require any specific file extensions. This includes files without any extension.

3. EDI allows up to a two gigabyte file to be uploaded.

4.8.6 Download Transmission Reports and ERA Using the Web Portal

Providers log on to the secure Web Portal, navigate to the Trade Files menu option, and download a file. The type of file is displayed under 'document type'. This includes all reports, HIPAA transactions (i.e. 820's and 835's) and electronic remittance advices. Additionally, authorized users can download non-HIPAA files.

4.9 Remote Access Server (RAS) Dial-Up Transmission

The RAS enables providers to access all options of the secure Web portal without the use of an Internet Service Provider. This option is available to users who do not have an existing Internet connection. The RAS server typically supports users that need a dial-up option. Trading partner data transmitted using the RAS can be transmitted the same as the Internet secure site using DDE or upload batch transactions.

After the connection is established, the landing page is presented. A user either logs on and is presented with their secure provider page, or selects 'register' if they are a first-time user.

Once logged on, the user will have access to the various secure Web portal options, including File Upload and File Download for EDI transactions.

4.10 Secure File Transfer Protocol (SFTP)

SFTP uses Secure Shell (SSH) to encrypt and then securely transmit data across a potentially unsecured connection. Functionally SFTP (required) is similar to FTP, but offers protection to sensitive data. Secure Shell or SSH is a network protocol that allows data to be exchanged using a secure channel between two networked devices.

This option allows provider, vendors, and all other trading partners to transfer claim files to HPES using the secure file transfer protocol server. Trading partners must notify us specifically if wishing to use this transmission method to transmit files.

HPES requires that the SFTP submitters send their public key and HPES exchanges its public key with the submitter for encryption purposes. HPES will setup a username and password for the submitter to access the server. Along with using SFTP, HPES requires that each file being transmitted over SFTP should be encrypted using PGP public-private key encryption because PHI data sits on DMZ zone for certain period. To achieve this HP Enterprise Services requires that the SFTP submitters exchange their PGP public key with HP Enterprise Services.

Note: Additional detailed information on the panels, steps, and processes using the SFTP server can be found in the SFTP Setup and Data Transfer Requirements guide.

4.11 Provider Electronic Solutions (PES)

HPES provides free software called Provider Electronic Solutions (PES) for the submission of claim transactions. The system PC minimum requirements for PES are Windows 2000 or higher. This software complies with HIPAA requirements and is available to all providers who wish to submit claims electronically. The HIPAA-ready manuals available for billing Georgia Medicaid using PES include:

1.   837 Professional

2.   837 Institutional (Inpatient and Outpatient Hospital)

3.   837 Dental

Georgia Medicaid providers can download a copy of the PES software from the Web Portal, have it sent using e-mail, or request a copy from the EDI Services to receive a CD through the United States Postal Service (USPS). A user manual, installation guide, and the initial password to access the PES application comes with the software. The EDI Services team will assist and answer any immediate questions or refer providers needing additional training to the Provider Relations team.

Note: For additional information regarding specific PES procedures and functionality, please locate the PES Manuals located on our website at www.mmis.georgia.gov under EDI, Software and Manuals. Each transaction has its own PES manual on the website, for the following services: Professional Claims (CMS-1500) Billing, Dental, and Inpatient and Outpatient Institutional (UB-04) claims. Refer to Appendix D regarding instructions on downloading and installing PES along with the PC system requirements. This manual will also include panels and billing instructions.

4.12 Value Added Networks (VANS)

VANs support interactive transactions for established vendors. VANs sign contracts with the State and set up unique VAN-specific communication arrangements with HP Enterprise Services.

4.13 Diskette/CD-ROM/DVD/Tape

Providers experiencing technical connection issues can mail a labeled copy of the EDI claims file downloaded on a CD-ROM, tape, or diskette. HPES does not anticipate that most providers will typically need to submit EDI transactions using diskette/CD-ROM/DVD/tape.

Note: This option is reserved for special instances where the provider is having critical internet connection issues preventing them from accessing the Web Portal or server. The CD-ROM/diskette must be labeled to identify the trading partner and instructions on where to locate the EDI file for upload or it will be returned as unprocessed to the provider.

Providers are responsible for correcting any connection issues to resume transmitting claims using the normal transmission methods (Web Portal, RAS, PES, or VANs). Refer to Appendix B for detailed handling procedures in the event HPES receives a diskette/CD-ROM/tape.

4.14 How to Submit an Institutional Claim on the Web Portal

The Institutional Claim page allows providers, payees and billing agents to view institutional claims which have processed with Georgia Medicaid. Rendering providers and billing agents acting as rendering providers may use the institutional claim page to submit a claim and/or adjust or void a paid claim. This includes the ability to copy a paid claim or modify a denied claim that can be sent to Georgia Medicaid and reprocessed as a new claim. Payees and billing agents acting as payees will be restricted to read-only access.

Attachments can be included as part of the web submission process. The ability to upload an electronic attachment is provided once the user submits the claim with a transmission type of electronic upload. If the response indicates the claim will be suspended for attachments, the upload ability will be provided for the user to attach their electronic file with the claim.

Providers and billing agents will automatically be restricted to viewing claims that have been processed with their provider ID as the rendering or payee provider. Billing agents may use the switch provider page to select and navigate on the web portal using a different provider ID account to view the appropriate claim.

Navigational Path: Claims – New Institutional Claim

Step	Action	Result
Start from the secured Claims menu.		

Step	Action	Result
1	Select the New Institutional Claim submenu.	The Institutional page displays.

Other Payer Claims Data

A				
Claim Filing	BLUE CROSS/BLUE SHIELD		Payer Identifier	123455
Relationship	SELF		Insurance Co Name	INSURANCE
Last Name	LAST		Group Name	GROUPNAME
First Name, MI Name	FIRST, M		Group or Policy #	POLICYNUM
Payer Resp	PRIMARY			
Authorization Number	3478859003993222222		Paid Date	05/01/2010
			Paid Amount	$33.44

Type data below for new record.

Claim Filing*	BLUE CROSS/BLUE SHIELD	Payer Identifier*	123455
Relationship*	SELF	Insurance Company Name	INSURANCE
Last Name*	LAST	Group Name	GROUPNAME
First Name, MI*	FIRST	M	Group or Policy Number	POLICYNUM
Payer Resp*	PRIMARY		
Authorization Number	3478859003993222222	Paid Date	05/01/2010
		Paid Amount	$33.44

delete   add

-Other Payer Adjustment Information-

The data below is for the row selected above.

	Claim Adjustment Group Code	Adjustment Reason Code	Adjustment Amount	Adjustment Quantity
A	Patient Responsibility	66	$30.30	3.40

Type data below for new record.

Claim Adjustment Group Code*	PR - Patient Responsibility	Adjustment Reason Code*	66
Adjustment Amount	$30.30	Adjustment Quantity	3.40

delete   add

Other Payer Adjustment Information Summary

Payer ID	Insurance Company Name	Claim Adjustment Group Code	Adjustment Reason Code	Adjustment Amount	Adjustment Quantity
123455	INSURANCE	Patient Responsibility	66	$30.30	3.40

Detail

A				
Item	1		Non Covered Charges	$44.00
From DOS	05/01/2010		Charges	$55.00
To DOS	05/01/2010		Status	
Revenue Code	100		NDC	00003401920
Revenue Code Desc	ALL INCL R&B/ANC		Drug Name	SUR-FIT NATURA POST OP
Procedure	0001T		Drug Unit Count	2.000
Procedure Desc	ENDOVAS REPR ABDO AO ANEURYS		Drug Unit of Measure	GR
Modifiers	21,22,23,24		Allowed Amount	$0.00
Units	33.00		CoPay Amount	$0.00
Units Of Measurement	UN		Paid Amount	$0.00

Type data below for new record.

Item	1	Non Covered Charges	$44.00
From DOS	05/01/2010	Charges*	$55.00
To DOS	05/01/2010	Drug Rebate Information	
Revenue Code*	100 [Search]	NDC	00003401920 [Search]
Revenue Code Description	ALL INCL R&B/ANC	Drug Name	SUR-FIT NATURA POST OP
Procedure	0001T [Search]	Drug Unit Count	2.000
Procedure Description	ENDOVAS REPR ABDO AO ANEUI	Drug Unit of Measure	Gram
Modifier 1	21 [Search]	Adjudication Information	
Modifier 2	22 [Search]	Status	
Modifier 3	23 [Search]	Allowed Amount	$0.00
Modifier 4	24 [Search]	CoPay Amount	$0.00
Units*	33.00	Paid Amount	$0.00
Units of Measurement*	Unit		

delete   add   copy

-Detail Other Payer Information-

The data below is for the row selected above.

	Detail Item	Payer ID	Paid Amount	Paid Date
A	1	123455	$3.40	04/03/2010

Type data below for new record.

Detail Item	1	Payer ID*	123455
Paid Amount	$3.40	Paid Date*	04/03/2010

delete   add

---Detail Other Payer Adjustment Information-

The data below is for the Detail Other Payer row selected above.

	Detail Item	Claim Adjustment Group Code	Adjustment Reason Code	Adjustment Amount	Adjustment Quantity
A	1	Patient Responsibility	1	$2.00	3.00

Type data below for new record.

Detail Item	1		
Claim Adjustment Group Code*		Adjustment Reason Code*	1
Adjustment Amount	$2.00	Adjustment Quantity	3.00

delete   add

Detail Other Payer Information Summary			
Detail Item	Payer ID	Paid Amount	Paid Date
1	123455	$3.40	04/03/2010

Detail Other Payer Adjustment Information Summary					
Detail Item	Payer ID	Claim Adjustment Group Code	Adjustment Reason Code	Adjustment Amount	Adjustment Quantity
1	123455	Patient Responsibility	1	$2.00	3.00

Hard-Copy Attachments		
Control Number	Transmission	Report Type
A XCY333333332999999993	Available on Request at Provider Site	Admission Summary

Type data below for new record.

Control Number* XCY333333332999999993

Transmission* Available on Request at Provider Site ▼

Report Type* Admission Summary ▼

delete   add

Claim Status Information

Claim Status Not Submitted yet

Claim Status Information

Claim Status Paid

Claim ICN 2288114333223

RA Paid Date 04/23/2008

Paid Amount $14.55

EOB Information

Detail Number	Code	Description
1	0296	PAY TO PROVIDER INELIGIBLE FOR DATE(S) OF SERVICE
2	0001	THIS IS A TEST MESSAGE

Adjustment Information

ICN	Date Adjusted
2333442223333	05/01/2008
3333334444444	06/01/2008

4.14.1 Creating a New Institutional Claim

Note: Fields marked with an asterisk are required. Otherwise, the field is optional.

Step	Action	Result
I. Institutional Claim		
1	Select Rendering Taxonomy from the drop-down list.	
2	Enter Member ID*.	
3	Enter the Member's Last Name*.	
4	Enter the Member's First Name*. Please note MI (middle initial) is an optional field.	
5	Enter Date of Birth*.	
6	Select Gender from the drop-down list*.	
7	Enter Patient Account #.	
8	Enter Medical Record #.	
9	Enter Attending Physician*.	
10	Enter Operating Physician.	
11	Enter Other Physician 1.	

Step	Action	Result
12	Select Type Of Bill from the drop-down list*.	
13	Select Type Of Bill frequency from the drop-down list*.	
14	Select Release of Information from the drop-down list*.	
15	Enter From Date*.	
16	Enter To Date*.	
17	Enter Admission Date.	
18	Enter Admission Hour.	
19	Select Admission Type from the drop-down list.	
20	Enter Admit Source or click [Search] to select from the list. Clicking [Search] activates the Admit Source Search panel.	
21	Enter Discharge Hour.	
22	Enter Patient Status or click [Search] to select from the list. Clicking [Search] activates the Patient Status Search panel.	
23	Enter PA/Pre-cert Number.	
24	Enter Referral Number.	
25	Enter Patient Responsibility.	
26	Enter Estimated Amount Due.	

II. Condition Section

Optional unless condition information needs to be included against the claim. Must click add to activate the panel before anything can be entered or selected.

1	Enter Sequence*.	
2	Enter Condition* or click [Search] to select from list. Clicking [Search] activates the Condition Search panel.	

III. Diagnosis Section

Must click add to activate the panel before anything can be entered or selected.

Step	Action	Result
1	Select Sequence from the drop-down list*.	
2	Select POA from the drop-down list.	
3	Enter Diagnosis or click [Search] to select from list*. Clicking [Search] activates the Diagnosis Search panel.	

IV. ICD Procedure Section
Optional unless ICD Procedure information needs to be included against the claim. Must click add to activate the panel before anything can be entered or selected.

Step	Action	Result
1	Enter Sequence*.	
2	Enter ICD or click [Search] to select from list*. Clicking [Search] activates the ICD Search panel.	
3	Enter ICD Date*.	

V. Occurrence/Span Section
Optional unless occurrence information needs to be included against the claim. Must click add to activate the panel before anything can be entered or selected.

Step	Action	Result
1	Enter Sequence*.	
2	Enter Occurrence Code or click [Search] to select from list*. Clicking [Search] activates the Occurrence Code Search panel.	
3	Enter From Date*.	
4	Enter To Date.	

VI. Value Section
Optional unless value information, such as covered and non-covered days, needs to be included against the claim. Must click add to activate the panel before anything can be entered or selected.

Step	Action	Result
1	Enter Sequence*.	
2	Enter Value or click [Search] to select from list*. Clicking [Search] activates the Value Search panel.	
3	Enter Amount.	

Step	Action	Result
VII. Other Payer Claims Data Section		
Optional unless Third Party Liability (TPL) and/or Medicare information needs to be indicated against the claim. Must click add to activate the panel before anything can be entered or selected.		
1	Select Claim Filing from the drop-down list*.	
2	Select Relationship to Insured from the drop-down list*.	
3	Enter policy holder Last Name*.	
4	Enter policy holder First Name*. Please note MI (middle initial) is an optional field.	
5	Select Payer Resp from the drop-down list*.	
6	Enter Authorization Number.	
7	Enter Payer Identifier*.	
8	Enter Insurance Company Name.	
9	Enter Group Name.	
10	Enter Group or Policy Number.	
11	Enter Paid Date.	
12	Enter Paid Amount.	
VIII. Other Payer Adjustment Information Section		
Optional unless Third Party Liability (TPL) and/or Medicare coinsurance, deductibles, etc, needs to be indicated against the claim. When the Payer ID selected is Medicare Part A for an inpatient type of bill, select the row(s) that appear to enter the appropriate Medicare Coinsurance or Deductible amounts if applicable. Otherwise, click add to activate the panel before anything can be entered or selected.		
1	Select Claim Adjustment Group code from the drop down list*.	
2	Enter Adjustment Reason Code*.	
3	Enter Adjustment Amount.	
4	Enter Adjustment Quantity.	
IX. Detail Section		
1	Enter From DOS.	

Step	Action	Result
2	Enter To DOS.	
3	Enter Revenue Code or click [Search] to select from list*. Clicking [Search] activates the Revenue Code Search panel.	
4	Enter Procedure or click [Search] to select from list. Clicking [Search] activates the Procedure Search panel.	
5	Enter Modifier 1 or click [Search] to select from list. Clicking [Search] activates the Modifiers Search panel.	
6	Enter Modifier 2 or click [Search] to select from list. Clicking [Search] activates the Modifiers Search panel.	
7	Enter Modifier 3 or click [Search] to select from list. Clicking [Search] activates the Modifiers Search panel.	
8	Enter Modifier 4 or click [Search] to select from list. Clicking [Search] activates the Modifiers Search panel.	
9	Enter Units*.	
10	Select Units Of Measurement from the drop-down list*.	
11	Enter Non Covered Charges.	
12	Enter Charges*.	
13	Enter NDC or click [Search] to select from list. Clicking [Search] activates the NDC Search panel.	
14	Enter Drug Unit Count.	
15	Select the Drug Unit of Measure from the drop-down list.*	

Step	Action	Result
X. Detail Other Payer Information Section		
Optional unless Third Party Liability (TPL) and/or Medicare information needs to be indicated against the claim detail. Must click add to activate the panel before anything can be entered or selected.		
1	Select the Payer ID from the drop-down list.* (This relates to the Payer Identifier entered on the Other Payer Claims Data panel.)	
2	Enter the Paid Amount.	
3	Enter the Paid Date.	
XI. Detail Other Payer Adjustment Information Section		
Optional unless Third Party Liability (TPL) and/or Medicare coinsurance, deductibles, etc, needs to be indicated against the claim detail. When the Payer ID selected is Medicare Part B for an outpatient type of bill, select the row(s) that appear to enter the appropriate Medicare Coinsurance or Deductible amounts if applicable. Otherwise, click add to activate the panel before anything can be entered or selected.		
1	Select the Claim Adjustment Group Code from the drop-down list.*	
2	Enter Adjustment Amount.	
3	Enter Adjustment Reason Code.*	
4	Enter Adjustment Quantity.	
5	Click add in Detail section to add another service line and repeat the steps in section IX and the steps in sections X and XI (if Medicare or TPL related).	Activates fields for entry of data or selection from lists.
XII. Hard Copy Attachments Section Optional unless attachment information needs to be included against the claim. Must click add to activate the panel before anything can be entered or selected.		
1	Enter Control Number*.	

Step	Action	Result
2	Select Transmission from the drop-down list*. Note: Submitting a claim with a transmission type of Electronic Upload allows the claim to suspend for needing an attachment if all other edits are bypassed. Once suspended for needing an attachment, the upload button is available on the Hard-Copy Attachments panel to begin attaching the appropriate .jpg, .jpeg, .pdf or .tiff file against the assigned ICN.	
3	Select Report Type from the drop-down list*.	
4	Click submit.	The institutional claim is submitted and an ICN is assigned.

4.14.2   Adjusting an Institutional claim

Step	Action	Result
Start from the secured Claims menu.		
1	Select the Search (Void, Adjust) submenu.	The Claim Search panel displays.
2	Enter the appropriate search criteria.	
3	Click Search.	The search results panel displays.
4	Select the institutional ICN to be adjusted.	The institutional claim is displayed in detail.
5	Click in the field(s) to update and perform update.	
6	Click adjust and OK to confirm the request.	The adjustment is submitted and the new daughter claim ICN and information is displayed. Note: If the adjustment is rejected, a new ICN beginning with "20" will appear with the appropriate denial reasons displayed on the EOB Information panel.

4.14.3 Voiding an Institutional Claim

Step	Action	Result
Start from the secured Claims menu.		
1	Select the Search (Void, Adjust) submenu.	The Claim Search panel displays.
2	Enter the appropriate search criteria.	
3	Click Search.	The search results panel displays.
4	Select the institutional ICN to be adjusted.	The institutional claim is displayed in detail.
5	Click void and OK to confirm the request.	The void is submitted and the new daughter claim ICN and information is displayed. Note: If the void request is rejected, a new ICN beginning with "20" will appear with the appropriate denial reasons displayed on the EOB Information panel.

4.14.4 Submitting Attachments Using Web Portal

Attachments can be included as part of the Web submission process. The ability to upload an electronic attachment is provided once the user submits the claim, through the Web Portal, with a transmission type of electronic upload. If the response the claim will be suspended for attachments, the upload ability will be provided for the user to attach their electronic file with the claim. If you are unable to submit attachments using the Web Portal - see Appendix C-10, Attachment form for Electronically Submitted Claims.

4.14.5 How to Download the Remittance Advice (RA) from the secure Web Portal

This produces a print image of the paper RA. All providers will have access to a PDF version of their RA. This is not the X12N 835 transaction. An 835 transaction is available to providers and trading partners that request it.

To access the PDF version of the RA:

1.   Log on to the secure Web site.

2.   Navigate to the Reports menu option and select the financial reports sub-menu.

3.   Complete the Reports search panel and click search to review the available RAs within the time period requested.

4.	To begin the download process, click the file name of the desired files to download.

5.	To download the report, click Save.

6.	Click Save.

7.	The Save As dialog box opens. Save the file to a local directory. The files may be renamed if desired, but it is not necessary to do so.

8.	Click Save.

9.	When the download process is complete, the download dialog box prompts to Open or Close the file. This is at the user's discretion.

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5 Claims Processing

5.1 Introduction

Claims for Medicaid reimbursement are processed by HP Enterprise Services. This chapter describes claims processing and gives the provider information about remittance advice and how to obtain help with claim processing.

5.2 Claims Processing

5.2.1 Paper Claim Handling

When HP Enterprise Services receives a paper claim, it is initially screened for missing information and necessary attachments. If information or documentation is missing, the claim will not be entered into the GAMMIS. It will be returned to the provider with a Mail Room Return to Provider (RTP) letter (see Appendix C.8) that will state the reason the claim is being returned. The provider must correct the error, attach any missing documentation, and return the claim to HP Enterprise Services for processing. Claims are returned when they cannot be processed for payment.

Examples of missing information required for processing claims include:

- Missing signatures

- Print or ink too light to microfilm

- Incorrect/incomplete attachments

- Incorrect claim type

- Provider number incomplete or missing

5.2.2 Claim Entry

Data entry operators image and key into the GAMMIS each paper claim that passes initial screening. Electronic claims are loaded by batch into the GAMMIS.

5.2.3 Claim Adjudication

The GAMMIS analyzes the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

5.3 Remittance Advice (RA)

5.3.1 Description

Medicaid and Medicaid/Medicare crossover claims which are paid, denied, adjusted, or placed in-process by the Division will be listed on the RA. The information contained on the RA is intended to assist the provider in reconciling Medicaid accounts and to assist the Division in guarding against false or erroneous billings. RAs will be provided to providers through the mail or the provider's Message Center on HP Enterprise Services Web Portal at www.mmis.georgia.gov. The electronic RAs are available in a HIPAA-compliant format and a PDF version of the paper RA.

5.3.2 Role of the Remittance Advice

The RA plays an important role in communications between the provider and Medicaid. It tells what happened to the claims submitted for payment – whether they were paid, denied, in process, or adjusted. It provides a record of transactions and assists the provider in resolving errors so that denied claims can be resubmitted.

The RA must be reconciled to the claim in order to determine if correct payment was received. The date on the first line of each page is the date the financial cycle began, e.g., Friday. The issue date is the date the check was mailed to the provider or an electronic funds transfer (EFT) was sent to the bank for transmission.

The RA contains one or more of the following sections, depending on the type of claim filed, the disposition of those claims, and any new billing or policy announcements. Each section starts on a new page:

1.   RA Banner Page Message which will be included on every RA

2.   Claim Statuses: Paid, Denied, In Process (includes suspended claims), Adjusted

3.   Financial Transactions

4.   Summary Section which will be included on every RA

5.   EOB Reason Code Description

5.3.3 Remittance Advice Banner Message

When Medicaid or HP Enterprise Services discovers billing problems encountered by all or select provider types, a RA banner message is printed as the first page. Suggestions for avoiding problems, explanations of policy, and new or changed procedure codes are described. Training sessions are also announced on the RA banner page.

5.3.4 Claim Statuses

Paid Claims: The RA will list each claim paid, the date of service, the amount paid for each service on the claim, and the total amount paid for each claim. Some paid claims may have disallowed lines. These disallowed lines are actually denied charges and may be resubmitted. The reason for the disallowance is listed to the left of the line that was disallowed.

Note: Same claims in paid status may have paid zero dollars.

In Process (includes Suspended claims): This RA will identify claims that require further research, evaluation, or other action by the Division before they can be paid or denied. As long as a claim is suspended, it is not necessary for a provider to submit a duplicate claim. The Pending Claims section will reflect only those claims that have entered the Division's computer system. Claims that have been received by HP Enterprise Services but are still being prepared for computer entry will not be shown. It is the responsibility of the provider to ensure that each and every claim is received by HP Enterprise Services within applicable deadlines for submission and resubmission. If a claim does not appear as pending, or if a claim ceases to appear

on the pending report and the provider is not aware of its payment or denial, the provider bears the responsibility for inquiring about the claim's status and taking appropriate action.

Denied Claims: The RA indicates the adjustment reason code(s) and remark code(s) which determine why a particular claim or service could not be paid. The denial of a claim constitutes the termination of the transaction between the Division and the provider for the services billed. Any reconsideration for payment must be initiated by the provider through a new claim. If the provider does not intend to resubmit the claim, the charges for the services should be written off any accounts receivable records maintained by the provider since no further action will be taken by the Division.

Adjustments: The RA will indicate positive adjustments to previous payments made to the provider and negative adjustments resulting from rate changes, retrospective review, or other actions by the provider or the Division.

5.3.5 Financial Transactions

The RA will indicate refund adjustments, recoupments subtracted from the amount payable, voluntary refunds by the provider, and lump sum payouts.

5.3.6 Summary Section

The Summary Section is used to denote the total of all claims for the provider's RA including Claims Data, Earnings Data, and Current Deductions. The total capitation payment is included on the summary page.

5.3.7 Explanation of Benefits (EOB) Reason Code Description

The EOB Reason Code section contains an explanation for all EOB codes and reason codes shown on all previous pages of the RA.

All claims for each provider that are entered in the GAMMIS during the weekly cycle are listed on a RA. Following are examples of each type of UB-04 RA and the field descriptions.

```
REPORT:   CRA-BANN-R                    GEORGIA DEPARTMENT OF COMMUNITY HEALTH              DATE: MM/DD/CCYY
RA#:         999999999                  MEDICAID MANAGEMENT INFORMATION SYSTEM             PAGE:      99999
                                             PROVIDER REMITTANCE ADVICE
                                                 BANNER MESSAGES


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX               PAYEE ID:      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              NPI ID:             9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                              PAYMENT NUMBER:      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                               ISSUE DATE:        MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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    ***********************************************************************************
    ***********************************************************************************

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XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

Figure 13: Illustration Banner Page Message

```
REPORT:   CRA-OPPD-R                        GEORGIA DEPARTMENT OF COMMUNITY HEALTH                           DATE:  MM/DD/CCYY
RA#:      999999999                         MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:      9,999
                                                   PROVIDER REMITTANCE ADVICE
                                               CLAIM TYPE O - OUTPATIENT PAID


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID:      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                    NPI ID:             9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                      PAYMENT NUMBER:      999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                     ISSUE DATE:         MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
--------------------------------------------------------------------------------------------------------------------------
COS  ICN          MEMBER ID    MEMBER NAME               TOB   BILLED DTE  MED REC NUMBER        PATIENT NUMBER
P AUTH NO     FROM DTE - THRU DTE        BILLED          ALLOWED      COPAY/DEDUCT           COB       TOTAL PAID
--------------------------------------------------------------------------------------------------------------------------
XXX  RRYYJJJBBBSSS  XXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXX    XXXX  MMDDYYYY   XXXXXXXXXXXXXXXXXXXXXX  RRYYJJJBBBSSSXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX   MMDDYYYY   MMDDYYYY     9,999,999.99       9,999,999.99        999,999.99       9,999,999.99      9,999,999.99        PAID
   HEADER EOBS:  9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-


LNN FROM DTE-THRU DTE  REV  PROC CD M1 M2 M3 M4    UNITS      BILLED       ALLOWED        COB       PAID  DETAIL EOBS              STATUS
XXX MMDDYYYY MMDDYYYY  XXX  XXXXXX  XX XX XX XX  9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   PAID
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                     9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
XXX MMDDYYYY MMDDYYYY  XXX  XXXXXX  XX XX XX XX  9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   PAID
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                     9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
XXX MMDDYYYY MMDDYYYY  XXX  XXXXXX  XX XX XX XX  9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   DENY
        DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DTE: MMDDYYYY                                  9999 9999 9,999,999.99-
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                     9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
    (The following detail is an example of procedure J-code, where the 11 character NDC code appears in the Modifiers section.)
XXX MMDDYYYY MMDDYYYY  XXX  XXXXXX  XX XX XX XX  9999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-   PAID
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                     9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

TOTAL OUTPATIENT CLAIMS PAID:     9,999,999,999.99    9,999,999,999.99    9,999,999,999.99    9,999,999,999.99    9,999,999,999.99
```

Figure 14: Sample UB-04 Claims Paid

```
REPORT:  CRA-IPDN-R                        GEORGIA DEPARTMENT OF COMMUNITY HEALTH                        DATE:  MM/DD/CCYY
RA#:        999999999                      MEDICAID MANAGEMENT INFORMATION SYSTEM                        PAGE:      9,999
                                                  PROVIDER REMITTANCE ADVICE
                                                CLAIM TYPE I - INPATIENT DENIED


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                   PAYEE ID:          999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                  NPI ID:                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                    PAYMENT NUMBER:          999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                   ISSUE DATE:             MM/DD/CCYY

RENDERING PROVIDER: MCD XXXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-------------------------------------------------------------------------------------------------------------------------
COS  ICN          MEMBER ID      MEMBER NAME                TOB    BILLED DTE  MED REC NUMBER          PATIENT NUMBER
PRECERT         FROM DTE - THRU DTE  DAYS  DRG PRICED    WEIGHT        BILLED         ALLOWED    COPAY/DEDUCT          COB       TOTAL PAID
-------------------------------------------------------------------------------------------------------------------------
XXX  RRYYJJJBBBSSS  XXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXX  XXXX  MMDDYYYY    XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXX MMDDYYYY    MMDDYYYY    999  XXX XXX      99.9999  9,999,999.99     9,999,999.99      999,999.99      9,999,999.99     9,999,999.99     DENY
  HEADER EOBS:  9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
               9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
               9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-


LNN FROM DTE - THRU DTE        BILLED       ALLOWED          COB        PAID  DETAIL EOBS                                       STATUS
XXX MMDDYYYY    MMDDYYYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99- 9999 9999 9,999,999.99-     DENY
        DUPLICATE ICN: RRYYJJJBBBSSS DTL: 999 PREV PAID DTE: MMDDYYYY           9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
               9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
XXX MMDDYYYY    MMDDYYYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99- 9999 9999 9,999,999.99-     DENY
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
               9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
XXX MMDDYYYY    MMDDYYYY  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99- 9999 9999 9,999,999.99-     DENY
    ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
               9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-

TOTAL INPATIENT CLAIMS DENIED:                          9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99
```

Figure 15: Sample UB-04 Claims Denied

```
REPORT:   CRA-LTSU-R                    GEORGIA DEPARTMENT OF COMMUNITY HEALTH              DATE:  MM/DD/CCYY
RA#:      999999999                     MEDICAID MANAGEMENT INFORMATION SYSTEM             PAGE:     9,999
                                             PROVIDER REMITTANCE ADVICE
                                        CLAIM TYPE L - LONG TERM CARE IN PROCESS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          PAYEE ID:          999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                       NPI ID:                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                         PAYMENT NUMBER:          999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                        ISSUE DATE:           MM/DD/CCYY


RENDERING PROVIDER: MCD XXXXXXXXXXXXXXX NPI XXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
-----------------------------------------------------------------------------------------------------------
COS  ICN          MEMBER ID     MEMBER NAME            TOB   BILLED DTE  MED REC NUMBER       PATIENT NUMBER
PRECERT      FROM DTE - THRU DTE  DAYS  LVL CARE    BILLED       ALLOWED    COPAY/DEDUCT    PT LIAB        COB    TOTAL PAID
-----------------------------------------------------------------------------------------------------------
XXX  RRYYJJJBBBSSS XXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXX XXXX MMDDYYYY    XXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX MMDDYYYY   MMDDYYYY   999  XXX     9,999,999.99   9,999,999.99     999,999.99    9,999,999.99   9,999,999.99   9,999,999.99   SUSP
HEADER EOBS:  9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
              9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
              9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-


LNN  FROM DTE-THRU DTE  REV  PROC CD   UNITS      RATE       BILLED       ALLOWED        COB       PAID  DETAIL EOBS            STATUS
XXX  MMDDYYYY MMDDYYYY  XXX  XXXXXX   9999.99   99,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-      SUSP
     ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                       9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
XXX  MMDDYYYY MMDDYYYY  XXX  XXXXXX   9999.99   99,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-      SUSP
     ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                       9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
XXX  MMDDYYYY MMDDYYYY  XXX  XXXXXX   9999.99   99,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9999 9999 9,999,999.99-      SUSP
     ADDNL RMRK CODES: 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-
                       9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99- 9999 9999 9,999,999.99-


TOTAL LONG TERM CARE CLAIMS IN PROCESS:      9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99 9,999,999,999.99
```

Figure 16: Sample UB-04 Claims in Process

```
REPORT:   CRA-TRAN-R                 GEORGIA DEPARTMENT OF COMMUNITY HEALTH              DATE: MM/DD/CCYY
RA#:         999999999               MEDICAID MANAGEMENT INFORMATION SYSTEM             PAGE:      9,999
                                          PROVIDER REMITTANCE ADVICE
                                            FINANCIAL TRANSACTIONS


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                        PAYEE ID:        999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        NPI ID:                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                        PAYMENT NUMBER:         999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                          ISSUE DATE:          MM/DD/CCYY


      --------------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS---------------

      TXN NUMBER      CCN          PAYOUT AMOUNT     RSN CODE
      99999999999   YYJJJBBBSSS     9,999,999.99     9999

      TOTAL PAYOUTS:    99,999,999.99

      ---------------NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS---------------

      CCN           REFUND AMOUNT     RSN CODE
      YYJJJBBBSSS     9,999,999.99     9999

      TOTAL REFUNDS: 99,999,999.99

      ----------------------------ACCOUNTS RECEIVABLE-----------------------

      AR NUMBER        SETUP DTE    RECOUPED THIS CYCLE     ORIGINAL     TOTAL RECOUPED       BALANCE    RSN CODE
      XXXXXXXXXXXXX     MMDDYYYY          9,999,999.99   9,999,999.99     9,999,999.99   9,999,999.99    9999

      TOTAL BALANCE                                                                     99,999,999.99
```

Figure 17: Sample RA Financial Transaction

```
REPORT:   CRA-SUMM-R                          GEORGIA DEPARTMENT OF COMMUNITY HEALTH                          DATE:  MM/DD/CCYY
RA#:       999999999                         MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE:       9,999
                                                   PROVIDER REMITTANCE ADVICE
                                                   REMITTANCE ADVICE SUMMARY


XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                          PAYEE ID:       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                         NPI ID:             9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                           CHECK/EFT NUMBER:    999999999
XXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                         ISSUE DATE:          MM/DD/CCYY


RENDERING PROVIDER: MCD XXXXXXXXXXXXXX NPI XXXXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                         ------------------------CLAIMS DATA------------------------

                                         CURRENT           CURRENT
                                         NUMBER            AMOUNT
                  CLAIMS PAID            999,999,999     9,999,999,999.99
                  CLAIM ADJUSTMENTS POSITIVE  999,999,999     9,999,999,999.99
                  CLAIM ADJUSTMENTS NEGATIVE (999,999,999)  (9,999,999,999.99)
                    TOTAL CLAIMS PAYMENTS  999,999,999     9,999,999,999.99
                  CLAIMS DENIED          999,999,999
                  CLAIMS IN PROCESS      999,999,999

                                         ------------------------EARNINGS DATA------------------------
                  PAYMENTS:
                     CLAIMS PAYMENTS                      9,999,999,999.99

                     CAPITATION PAYMENT†                 9,999,999,999.99
                     SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)  9,999,999,999.99
                     ACCOUNTS RECEIVABLE (OFFSETS):      (9,999,999,999.99)
      :              ACCOUNTS RECEIVABLE (CLAIM SPECIFIC):(9,999,999,999.99)

                     NET PAYMENT**                       9,999,999,999.99

                  REFUNDS:
                     CLAIM SPECIFIC ADJUSTMENT REFUNDS   (9,999,999,999.99)
                     NON CLAIM SPECIFIC REFUNDS          (9,999,999,999.99)

                  OTHER FINANCIAL:
                     VOIDS                               (9,999,999,999.99)

                  NET EARNINGS                            9,999,999,999.99

                              -----CURRENT DEDUCTIONS------
                     LIEN HOLDER NAME/TYPE                       DEDUCTION AMOUNT
                     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX         9,999,999,999.99

**  NET PAYMENT AMOUNT HAS BEEN REDUCED.  LIEN PAYMENTS HAVE BEEN MADE TO THE FOLLOWING LIEN HOLDERS.

†  CAPITATION PAYMENT FOR THE MONTH OF MM/YY.  PLEASE REFER TO YOUR CAPITATION PAYMENT LISTING FOR ADDITIONAL DETAIL.
```

Figure 18: Sample RA Summary

5.4 How to Read the Remittance Advice

Figure 19: Sample UB-04 Claim Adjustments

Field Title ID	Field Title	Field Title Description
1	RA #	RA number is a unique identifier assigned to the remittance advice.
2	Payee Name	The name of the payee displayed above the address.
3	Address	The 'Pay To' mailing address of the payee. Displayed in the upper left corner of the remittance advice.
4	Payee ID	This is the unique identifier for the billing entity receiving payment or remittance activity.
5	NPI ID	This is the National Provider ID number that is associated with the provider on the remittance advice.
6	Payment Number	If a check was generated, this is the check number corresponding to the check that was generated. If the provider is an EFT participant, this is the control number of the EFT transaction.
7	Issue Date	This is the date the payment was issued.
8	Rendering Provider	The identifier of the provider that performed the service (for example, prescribed the drug, performed the dentistry, etc.).
9	Rendering Provider MCD	The Medicaid ID of the rendering provider.
10	Rendering Provider NPI	The NPI ID of the rendering provider.
11	Rendering Provider Name	The name of the rendering provider.
12	ICN	Internal Control Number (ICN) is a unique number used to identify and track a claim processed through the system. Format is RRYYJJJBBBSSS where RR is region, YY is year, JJJ is Julian day, BBB is batch, and SSS is claim sequence.

Field Title ID	Field Title	Field Title Description
13	Precert	This is the number assigned by the PA team to a PA request. (Inpatient and LTC only).
14	Member ID	The unique Medicaid identifier of the beneficiary (member).
15	Member Name	The name of the beneficiary (member) identified on the claim.
16	TOB	The location at which a service was rendered, such as office, home, emergency room, and so on.
17	Billed Dte	Date on which the provider or billing service prepared the claim form to be submitted.
18	Med Rec Number	Medical Record Number
19	P Auth No	This is the number assigned by the PA team to a PA request. (Outpatient only)
20	Patient Number	The Patient Control Number is a unique number assigned by the provider. This is usually used for filing or tracking purposes.
21	COS	Code for the state category of service (COS) that defines the grouping of services appearing on state MAR reports.
22	From Dte (Header)	This is the earliest date of service or admission date for the claim.
23	Days	This is the total number of days the member was in the hospital.
24	Lvl Care	This is the level of care. (LTC only)
25	DRG	This is a three-byte code field used to identify a DRG grouping. The DRG code and description are obtained from HCFA. (Inpatient only)

Field Title ID	Field Title	Field Title Description
26	Priced	Code used to identify the rate type to use in determining provider reimbursement. (Inpatient only)
27	Weight	This is a date sensitive pricing factor expressed in the 9.9999 form, and is one of the primary components for the DRG calculation. Some DRGs will not be assigned weights, so for these the Level of Care pricing method will be used. (Inpatient only)
28	Thru Dte (Header)	This is the latest date of service or discharge date for the claim.
29	Billed (header)	This is the dollar amount requested by the provider for the claim. The Header Billed Amount is arrived at by adding the Detail Billed Amounts on all the detail lines.
30	Allowed (header)	This is the computed dollar amount allowable for the claim. The header amount is arrived at by pricing each of the individual details and adding up the individual prices.
31	Copay/Deduct	The dollar amount of member responsibility on a claim that is to be collected by the provider at the time the service is rendered. Copay is used interchangeably with coinsurance. The Header Copay Amount is arrived at by adding the Detail Copay Amounts on all the detail lines.
32	COB (Header)	TPL Amount is the dollar amount paid by sources other than the state Medical Assistance Program being billed. If present, this amount is subtracted from the allowed amount.
33	Total Paid	This is the dollar amount that is payable for the claim.
34	Adj Rsn	Adjustment Reason is the EOB code entered when the claim was adjusted, indicating the reason for initiating the claim adjustment.
35	Voided Claim Indicator	This field contains *VOID* when the adjustment claim voids the original claim.

Field Title ID	Field Title	Field Title Description
36	Header EOBs	These are the Explanation of Benefits (EOB) codes that apply to the claim or adjustment header. These codes are used to explain how the claim or adjustment was processed or priced. There could be a maximum of 20 EOB codes. For each "EOB", the RA will display the System EOB Code the corresponding HIPAA Adjustment Reason Code and the cutback amount. Each "EOB" will be variable in length, from 4 to 23.
37	LNN	The number of the detail on a claim record.
38	From Dte (Detail)	This is the earliest date of service or admission date for the claim detail.
39	Thru Dte (Detail)	This is the latest date of service or discharge date for the claim detail.
40	Billed (Detail)	This is the dollar amount requested by the provider for the item billed on each detail line.
41	Allowed (Detail)	This is the computed dollar amount allowable for the detail item billed.
42	COB (Detail)	TPL Amount is the dollar amount paid by sources other than the state Medical Assistance Program being billed. If present, this amount is subtracted from the allowed amount.
43	Paid	This is the dollar amount that is payable for the claim.
44	Detail EOBs	These are the Explanation of Benefits (EOB) codes that apply to the claim detail lines. There could be a maximum of 20 EOB codes per detail line. For each "EOB", the RA will display the System EOB Code the corresponding HIPAA Adjustment Reason Code and the cutback amount. Each "EOB" will be variable in length, from 4 to 23.
45	Status	The claim line item status: PAID, DENY, SUSP.

Field Title ID	Field Title	Field Title Description
46	Addnl Rmrk Codes	This is a continuation of the Detail EOBs in the event that they do not all fit in the Detail EOB space.
47	Duplicate DTL	The number of the detail line that was a duplicate of the detail shown. This field is only shown when the claim detail was denied because there was a duplicate claim detail.
48	Duplicate ICN	The ICN of the claim that was a duplicate of the claim shown. This field is only shown when the claim header or detail was denied because there was a duplicate claim header or detail.
49	Prev Paid Dte	The previous paid date of the claim that was a duplicate of the claim shown. This field is only shown when the claim was denied because there was a duplicate claim.
50	Additional Payment	This is an additional payment.
51	Net Amount Owed To State	This is the additional amount owed by a billing provider as the result of a claim adjustment. If this amount cannot be recovered in the current cycle, an accounts receivable record is generated.
52	Provider Refund Amount Applied	The Refund Amount Applied is the amount of a cash receipt received from the provider applied to a cash related claim adjustment.
53	Total UB-04 Claim Adjustments	This is the grand total dollar amounts for this section of the remittance report.

5.5 How to Resubmit a Denied Claim

Check the RA before submitting a second request for payment.

Claims may be resubmitted for one of the following reasons only:

- The claim has not appeared on a RA as paid, denied, or suspended for 30 days after it was submitted.

- The claim was denied due to incorrect or missing information, or lack of a required attachment.

Do not resubmit a claim denied because of Medicaid program limitations or policy regulations. Computer edits ensure that it will be denied again.

Resubmitted claims must be original claims, not copies.

If the claim does not appear on a RA within 30 days of the day the provider mailed it, the following steps should be taken**:**

- Check recently received RA dates. Look for gaps. A RA may have been mailed but lost in transit. If the provider believes this is the case, call HP Enterprise Services Provider Service Contact Center at 1-800-766-4456 and select option 0.

- If there is not a gap in the dates of RA received, please call HP Enterprise Services Provider Services Contact Center at 1-800-766-4456 and select option 0. A representative will research the claim.

- If HP Enterprise Services advises that the claim was never received, please resubmit another claim immediately. See the Resubmission Checklist on the following page.

If the claim has denied for incorrect or missing information, correct the errors prior to resubmitting the claim.

5.5.1 Resubmission Checklist

Use the following checklist to ensure that resubmittals are completed correctly before submitting.

- Did you wait 30 days after the original submittal before resubmitting a missing claim?

- When completing a new claim, did you type or print the form in black ink? Are all multi-part copies legible?

- If you have corrected or changed the original claim form, have strikeovers been corrected on each copy? Do not use whiteout.

- Has the resubmitted claim been signed again and dated?

- Have you included all required attachments and documentation with the claim form?

- Is the claim clean of all highlighting and whiteout?

- Do you have the correct P.O. Box number and corresponding nine-digit ZIP code for mailing the resubmitted claim? Resubmitted claims should be sent to the same P.O. Box as the original claim.

Do you have any questions about resubmitted claims that are not answered in this manual? If so, please contact HP Enterprise Services Provider Contact Services Center at 1-800-766-4456 and select option 0.

5.6 When to Submit an Adjustment and Void

The adjustment and void process allows any adjudicated individual or multiple claims to be adjusted or reprocessed due to a rate change or a claim data error. Paid claims are adjusted and denied claims are reprocessed. Adjustments may be submitted by DCH, by the provider, or can be system generated resulting in an adjudicated claim with updated data. The end result for a void is a denied claim. Refer to section 205 of the Part I Policy and Procedures Manual for more information.

5.6.1 Adjusting an Incorrect Payment

A provider who receives an incorrect payment for a claim or receives payment from a third party after Medicaid has made payment is required to submit an adjustment or a void to correct the payment. Refer to section 205 of the Part I Policy and Procedures Manual.

5.6.2 Adjustment

An adjustment is needed if the correction to the payment would result in a partial refund or the claim was underpaid. Only paid claims can be adjusted. Adjustment requests must be received within three months following the month of the Medicaid payment. The payment date is reflected in the date located in the top right hand corner of the RA page. When an adjustment is performed, the original claim is voided resulting in the recovery of the entire paid amount. A new claim, the adjustment claim, is then created in the system, which incorporates the necessary requested changes and repays the provider for the services rendered. A paid claim can only be adjusted once due to this void and recovery process; however, an adjustment can be requested to the adjustment claim if additional changes are needed.

5.6.3 Void

A void is needed if the correction to the payment would result in a complete refund of the Medicaid payment to HP Enterprise Services **for the following reasons:**

- A provider was overpaid for a claim.

- A provider was not reimbursed for the correct amount.

- The individual receiving treatment, listed on the RA, is not a patient of the provider who received the RA.

- A payment was received by the wrong provider, and the payment is returned.

- A claim was paid to the provider twice.

- A check was paid to a provider who does not belong to the group or has left the group.

- The payment was inappropriately made payable to the wrong location or provider identification number.

5.7 Financial Summary Page Adjustment

5.7.1 Adjusting a Paid Claim

You must submit an Adjustment Request form or adjust the claim using the Web Portal to correct the claim payment when:

- An inaccurate claim payment is received.

- A payment was received from a third party after Medicaid has paid.

If you submit on paper, the Adjustment Request form must be submitted for each claim to be adjusted. The adjustment request must be submitted with a copy of the RA that corresponds to the claim payment.

Mail all Adjustment Request forms to:

HP Enterprise Services

Attn: Adjustment Request

P.O. Box 105206

Tucker, GA 30084-5206

5.7.2 Refund Adjustments Due to Error

You should use a personal/company check to refund a Medicaid overpayment. If the overpayment is due to an error on the claim, then you can include a completed Adjustment Request form with the overpayment refund. The completed form should include, within the narrative, the correct data to be applied to the claim.

5.7.3 Refund Adjustments Due to Third-Party Overpayment

You must refund payments that were received from a third party after Medicaid had already paid the claim. Adjustments can also be done on the Web, creating a receivable against future payments. A refund is due within 30 days after the provider received the overpayment. Along with the refund check, the provider should also send these three items:

- A completed Adjustment Request form

- A copy of the Medicaid RA that corresponds to the claim payment

- A copy of the RA received from the third party

All refund checks and accompanying documentation must be mailed to the following address. Providers and hospitals use separate addresses.

Provider
Bank of America
Lock Box 277941
Atlanta, GA 30384

Hospital
Bank of America
Lock Box 406867
Atlanta, GA 30384

5.7.4 Filing Limitation

Adjustment requests must be received within three months following the month of Medicaid payment. The payment date is reflected in the date located in the top right hand corner of the RA page. Only paid claims can be adjusted. When an adjustment is performed, the original claim is voided resulting in the recovery of the entire paid amount. A new claim, the adjustment claim, is then created in the system, which incorporates the necessary requested changes and repays the provider for the services rendered. A paid claim can only be adjusted once due to this void and recovery process; however, an adjustment can be requested to the adjustment claim if additional changes are needed. Refer to the Adjustment Request form (DMA-501) in section 5.9 for instructions on how to complete it.

5.7.5 Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services for Medicaid/Medicare members, notify the appropriate Medicare Fiscal Intermediary of your appeal. Any additional payment is through both Medicare and Medicaid. If the payments are made to an incorrect provider or are above the amount due, return the erroneous checks or issue refunds to Medicare and to Medicaid for their respective shares. Any erroneous Medicaid payments or refunds due to DCH must be forwarded to the following address:

Provider

Bank of America

Lock Box 277941

Atlanta, GA 30384

Adjustment Request Form

HP Enterprise Services

P.O. Box 105206

Tucker, GA 30084-5206

5.8 Adjustment Request Form (DMA-501)

Complete the Adjustment Request Form (DMA-501) as completely and accurately as possible. Incomplete or inaccurate information can delay the adjustment process. **Reminder:** If you submit on paper, attach a copy of the associated RA page before mailing your request.

Figure 20: Adjustment Request Form (DMA-501)

Completion of the Adjustment Request Form

Field	Description	Guidelines
1	Transaction Control Number (TCN) / Internal Control Number (ICN)	Enter the 13-digit ICN or the 17-digit TCN assigned to the claim.
2	Member Medicaid Number	Enter the member number exactly as it appears on the RA for the TCN or ICN.
	Member Name	Enter the name of the member exactly as it appears on the RA for the TCN or ICN.
3	Provider Name / Address	Enter the provider's name and address.
	Provider Number	Enter the identifying number assigned by the Provider Enrollment Unit.
	Phone Number	Enter the telephone number, including area code.
	Provider Contact Person	Enter the name of a person who can be contacted regarding the adjustment, if necessary.
4	Reason for Adjustment	Mark an 'X' in the box that best explains the adjustment.
5	Please list the information to be corrected in fields 5A-5D. If the information to be corrected does not have a line number, enter zero in the line number field. COB applied should always be line #0.	Complete 5A-5D as needed.
5A	Line to be Corrected	Enter the line from the RA in field 5A.
5B	Information to be Changed	Write the item to be changed in field 5B, such as procedure code, quantity.
5C	From (Current) Information	Enter the incorrect information in field 5C as it appears on the RA, such as procedure, quantity.
5D	To (Corrected) Information	Write the corrected information for that item in field 5D.

Field	Description	Guidelines
6	Explanation for Adjustment	Use this area to list any additional information that may be needed to process the adjustment request. Always attach a copy of the RA page showing the paid claim information to clarify your request.
7	For DCH Use Only CCN FS Line Amount$	Leave blank.
	Provider Signature and Date	The provider must sign and enter the date.

5.9 Return to Provider Adjustment Letter

Examples of missing information required for processing adjustment/voids include:

- Missing signatures

- Print or ink too light to microfilm

- Incorrect/incomplete attachments

- Incorrect claim type

- Provider number incomplete or missing

The adjustment/voids are returned when possible. To process for payment, the adjustment/voids must be resubmitted with the corrected or additional information. Adjustment Return to Provider (RTP) letter attached to the adjustment/voids lists the reason for the returned information.

An example of the Adjustment Return to Provider Letter is shown on the following page. (see figure 22).

hp

Provider Name _____   Date: _____

Address Line 1 _____

Address Line 2 _____

City, State Zip Code _____

Dear Provider:

The attached adjustment(s) is being returned for the following reason(s). These items require correction before the adjustment(s) can be processed. Please make the necessary corrections and resubmit for processing.

☐ **PROVIDER NUMBER MUST BE 9 DIGITS**

    ☐ Missing
    ☐ Incorrect
    ☐ Not legible
    ☐ Does not match originally paid claim

☐ **PROVIDER SIGNATURE:**
    ☐ Missing

☐ **MEMBER NUMBER MUST BE 12 DIGITS**
    ☐ Missing
    ☐ Incorrect
    ☐ Not Legible
    ☐ Does not match originally paid claim

☐ **SIGNATURE DATE/DATE BILLED:**

    ☐ Missing

    ☐ Not legible

☐ **TYPE OF BILL(UB-04):**
    ☐ Missing
    ☐ Invalid
    ☐ Not legible
    *Refer to Provider Manual for valid Medicaid
    Type Of Bill codes.

☐ **ICN MUST BE 13 DIGITS**
    ☐ Invalid digit number
    ☐ ICN is not 13 digits
    ☐ Missing
    ☐ Only one ICN per claim form

☐ **PLEASE INDICATE THE FOLLOWING::**
    ☐ Please mark the desired changes on claim form:
    (A) for Adjustment or (V) for Void
    ☐ Please select information to correct

☐ **CLAIM FORM IS NO LONGER ACCEPTED. RESUBMIT CHARGES ON VALID CLAIM FORM.**

☐ **VOIDED CLAIM CANNOT BE ADJUSTED**

☐ **SUSPENDED CLAIM CANNOT BE ADJUSTED**

☐ **DENIED CLAIMS CANNOT BE VOIDED/ADJUSTED**
    *Please submit new claim form

☐ **CLAIM IS IN PROCESS BY ANOTHER ICN:**

    _____

☐ **BLACK AND WHITE CLAIM FORM NOT ACCEPTED.**

☐ **EOMB INFORMATION DIFFERENT FROM CLAIM INFORMATION:**
    ☐ Dates of Service
    ☐ Member Name
    ☐ Billed Amount
    ☐ Procedure Code
    ☐ Resubmit on HCFA 1500 Claim Form
    ☐ Resubmit on UB04 Claim Form

☐ Adjustment(s) exceeds filing time limit of 3 months. Your adjustment request can not be processed.

☐ **TOTAL CHARGE CONFLICT**

☐ **OTHER:**
_____
_____

Adjustment Clerk ID:

If you have any questions, please contact our Call Center, open Monday through Friday, 7am to 7pm at 800-766-4456. Have you seen our web site? Georgia Medicaid Information is available, free of charge, through Georgia Medicaid's web site at http: www.mmis.georgia.gov

Figure 21: Adjustment Return to Provider Letter

6 Provider Services Contact Center

6.1 Introduction

The Provider Services Contact Center is a key source of support for Georgia Medicaid related matters. The Provider Services Contact Center team of inquiry specialists serves as an important resource for billing information. Providers interact with the Provider Services Contact Center by telephone.

HP Enterprise Services' Provider Services Contact Center is staffed Monday to Friday, between the hours of 7:00 a.m. and 7:00 p.m., Eastern Standard Time. HP Enterprise Services maintains both English and Spanish speaking specialists.

The Provider Services Contact Center is dedicated to responding professionally and accurately to provider inquiries. Provider contact and support is typically related to one of the following areas:

1.   Billing procedures

2.   Claims disposition

3.   Reimbursement

4.   Member's eligibility

5.   Prior Authorization (PA) status

All Provider Services Contact Center specialists and provider contacts are tracked and recorded for quality purposes.

6.2 Provider Interactive Voice Response System (IVRS) Basic

The Georgia Provider and Member IVRS provide automated access to common inquiries that may be answered over the telephone. This system acts as a first line of support to providers and members by supplying participant information. When callers need further assistance, they can access the Provider Services Contact Center. The IVRS also provides automated access to the Nurse Aide Registry and supports providers and nurse aides in obtaining forms and training program information.

The IVRS is equipped to allow providers to perform multiple requests such as:
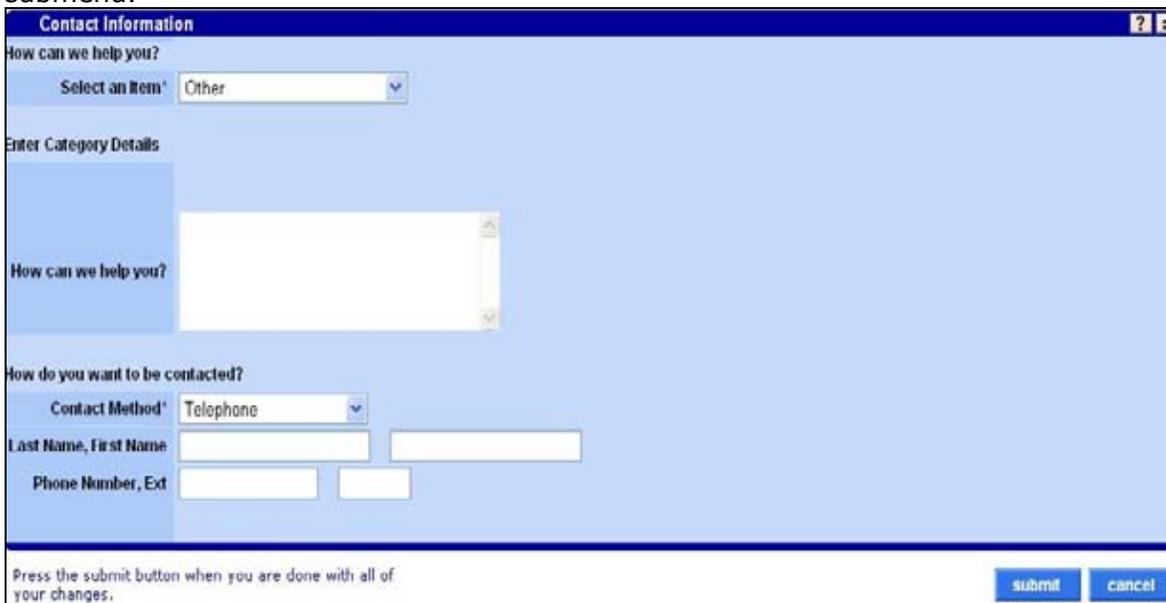
1.   Member eligibility

2.   Claim status

3.   Payment information

4.   Service limits

5.   Prior authorization status

6.   Speak to a Provider Services Contact Specialist

Providers can reach a Provider Services Contact Specialist through the following phone numbers:

1. Toll-free IVRS phone number: 1-800-766-4456

2. Local IVRS phone number: 404-298-1228

3. Providers not enrolled in the Georgia Medicaid Program can contact other departments within HP Enterprise Services IVRS without a provider number:

   a. Provider Enrollment

   b. EDI

6.3 The Contact Us Function on the Web Portal

The Web Portal is equipped with a public contact page that allows any user to contact Georgia Medicaid regarding a complaint, request, suggestion, etc. The Contact Information panel is located on our website at www.mmis.georgia.gov. Users will navigate to the Contact Information menu and select Contact Us from the available submenu.

6.4 The U.S. Mail

HP Enterprise Services and DCH anticipate that written requests are typically submitted using the Provider Inquiry Form (DMA-520) and the Provider Inquiry Form for Medical Claims and PA/UM (DMA-520A).

When a written inquiry is received the following key information is needed:

1.   Inquirer's name

2.   Phone number

3.   Provider number

4.   Member ID number, if applicable

When submitting an inquiry to the Written Correspondence Contact Center team using the Provider Inquiry Form (DMA-520, see figure 23) photocopy and complete the form with the appropriate information. Mail the form to the address shown below.

Written inquiries may be mailed to the following address when using the DMA-520:

HP Enterprise Services Written Inquiry

P.O. Box 105200

Tucker, GA   30058-5200

Provider Inquiry Form

Provider Number:	Instructions:
Provider Name:	*Use one form per inquiry.
Provider Address:	*Select the appropriate box below for completion.
	A. General Inquiry
	State the nature of your inquiry. Be as specific as possible. Please include a copy of your remittance advice as appropriate.
Contact Person:	
Telephone#: EXT:	B. Non Medical Claim Inquiry
Date of Inquiry:	Use this box when requesting an initial review of a denied claim. Request must be within 30 days of date of the denied claim.

Mail form to: HP Enterprise Services
                     P.O. Box 105200
                     Tucker, GA. 30085-5200

If this inquiry is about a member, please include the information requested below. Don't forget to indicate if the data was taken form an RA (Remittance Advice) or a claim.

	Fax form to: 1-866-483-1045
Member Name: Last First M.I.	
Member ID Number:	
Date of Service:	
Date of RA:	
Date Taken from:	
Internal Control Number from RA:	

Please Complete only one Section below: General Inquiry or Non Medical Claim Inquiry.

A. General Inquiry

_____

_____

_____

B. Non Medical Claim Inquiry

_____

_____

_____

DMA – 520 Rev 07/10   This form may be Photocopied

Figure 22: Provider Inquiry Form (DMA-520)

When submitting an inquiry to the Georgia Medical Care Foundation (GMCF) using the Provider Inquiry Form for Medical Claims and PA/UM (DMA-520A, see figure 24) photocopy and complete the appropriate information. This form is to be used by providers requesting inquiries relating to medical review issues. The form is to be submitted electronically through the Web Portal inquiry or can be faxed to 1-866-483-1044.

DMA 520A
Provider Inquiry Form for Medical Claims and PA/UM

Date of Inquiry:	**Instructions:**
Web-Portal Tracking #:	• Only one DMA-520A may be used per inquiry.
☐☐☐☐☐☐☐☐☐☐☐	• Please indicate the Web-Portal Tracking # on the DMA-520A form. If the Web-Portal Tracking # is blank the inquiry request will be returned.
Provider Information	
Provider Name:	• This form is only to be used for GMCF Medical Claims and PA/UM inquiries.
Provider Number:	• Submit supporting documentation for your medical claims inquiry.
Provider Address:	• The inquiry should be submitted within 30 days of the denial.
	• Please refer to Part I, Policies & Procedures, Section 502.
	• Electronically attach the DMA-520A form to the web-portal inquiry.
Provider E-mail address:	• Fax DMA-520A form to: 678-527-3066/local or 877-399-7142/toll free.
Provider Contact Numbers: Office #: ( ) ext. Fax #: ( )	
Contact Person & Number:	
Member Information	**Medical Claims Inquiry**
Member Name: Last First Initial	**ICN number:** (This # is required. If left incomplete the DMA-520A will be returned.) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Member Number:	**Date of Service:**
	RA number:
PA/UM (Prior Authorization) Inquiry	**Billed amount:**
PA number: (This # is required. If left incomplete the DMA-520A will be returned.) ☐☐☐☐☐☐☐☐☐☐☐	**Claim denial date:**
PA denial date: Please state your question regarding this PA. Do not use this form for a reconsideration, which may be done via the web or fax.	**Please state your concern regarding this medical claim.** (Supporting documentation should be submitted.)

DMA-520A (7/10)

Figure 23: Provider Inquiry Form for Medical Claims and PA/UM (DMA-520A)

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Appendix A Resource Tools

This appendix describes how to use the following resource tools:

- Telephone Inquiry

- Medicaid Eligibility Inquiry

- Billing Assistance

- Enrollment Changes

- Return To Provider Letter

A.1 Telephone Inquiry

You can speak with a live Provider Services Contact Specialist, Monday through Friday, 7:00 a.m. to 7:00 p.m. Eastern Standard Time (except holidays). Following are the telephone numbers you can use to contact us:

1-800-766-4566 (toll free)

The Provider Contact Services Center will respond to inquiries regarding:

- Billing procedures

- Claims payment/status

- Electronic claim submission

- Program benefits

- Service limitations

- Web Portal functionality

A.2 Medicaid Eligibility Inquiry

Be prepared to provide the information listed below so the Provider Services Contact Specialist can best assist you with your inquiry:

- The 13-digit ICN found on each claim from your RA

- Provider Number

- Transaction Control Number (TCN)

- Date(s) of Service

- Claim Status (Paid, Denied, In Process, Suspended)

- Member Name and Medicaid number

- The Explanation of Benefit (EOB) or error message, if applicable to your claim

A.3 Billing Assistance

The policy and billing manuals are always the first point of reference for questions. The billing manual reviews:

- Required claim forms and necessary information

- Sample RAs with explanations

- Billing protocol

- Order information for forms

Billing training and EDI assistance is available to:

- Assist you with billing problems

- Install PES software for electronic billing

- Review billing with your team

- Call the telephone inquiry line to request billing training or assistance

A.4 Provider Enrollment Changes

As a condition of continued Medicaid provider participation, all notifications of changes in address or enrollment must be made in writing. Enrollment changes that might affect claim reimbursement and that should be reported in writing include:

- Address/location

- Name of institution or business

- Telephone number

- License information

- Medicare provider numbers

- Federal employer identification numbers

- Social Security number (SSN)

- Payee identifying information

- Ownership information

All checks for claim reimbursements that have been determined to be undeliverable by the post office are returned to the Financial Operations team at HP Enterprise Services. Financial Operations personnel attempt to contact the provider by telephone to determine why the check was returned. If the check was returned due to an unreported address change, the provider is requested to forward a notification

of change of address in writing to the HP Enterprise Services Provider Enrollment team. Upon receipt of the updated information, the check is mailed to the new address by the Financial Operations team. The reimbursement check is held in the HP Enterprise Services Financial Operations team until the change information has been received, if the days held exceed 90 to 180 days then the check will be voided.

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Appendix B NPI Requirements

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It is a 10-digit number assigned to health care providers. Once a provider has an NPI, it will not change regardless of job or location changes. It replaces all existing health care provider identifiers including numbers assigned by Medicare, Medicaid, Blue Cross, etc. on standard HIPAA transactions. It will be the number used to identify providers nationally.

B.1 Who needs an NPI?

All Medicaid providers, both individuals and organizations, who are eligible to receive an NPI, are required to have an NPI. This includes:

- All Medicaid healthcare providers

- All CMO healthcare providers

B.2 The NPI will be required on electronic claims.

Medicaid providers who are not eligible to receive an NPI will maintain their current Medicaid Provider ID.

B.3 When do I need to use my NPIwith Georgia Medicaid?

- Applying to be a Medicaid Provider

- On all electronic claims submission including claims submitted using PES

- Submitting any X12N (HIPAA) transaction that requires NPI

B.4 When do I need to use my Medicaid Provider Number?

You will need to use your Medicaid Provider Number in the following circumstances:

- Paper claims submission

- Resubmission of electronic claims on paper

- Submission of Web claims

IVRS inquiries

- Provider authentication

- All claim inquiries

- All other inquiries

Telephone inquiries

- Provider authentication

- All claim inquiries

- All other inquiries

Prior authorizations

- Requests

- Inquiries

Referrals

- Request

- Inquiries

Medicaid forms

B.5 When do I need both my NPI and my Medicaid Provider Number?

- Adding a location to my provider record

- Changing my provider information

- Written inquiries and correspondence

- E-mail and Contact Us inquiries

Appendix C Miscellaneous Forms and Attachments

This section contains examples of miscellaneous forms and attachments used for billing. Providers must refer to their specific Provider Contract, formerly known as Category of Service (COS), Part II Policies and Procedures Manual for detailed instructions on how to complete these forms. To view and print other DCH forms and attachments, visit the HP Enterprise Services Web Portal at www.mmis.georgia.gov, navigate to the Provider Information menu and select Forms from the available submenu.

C.1 Prior Authorization Request Form (DMA-80 or DMA-81)

As a condition of reimbursement, the Division requires that certain services or procedures be approved prior to the time they are rendered. This process is called Prior Approval. Prior Approval pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. Please refer to your Part II manual specific to the Provider Contract formerly known as the Category of Service (COS), for detail requirements.

PRIOR AUTHORIZATION REQUEST

GMCF
1455 Lincoln Pkwy Suite 800
Atlanta, GA. 30346

FOR DMA USE ONLY

Include this number on all claim Forms———————————→

PRIOR AUTHORIZATION NO

1. Member Name(Last, First, Middle Initial)		2. Medicaid ID No.	
3. Birth date	4. Sex	5. Address	Nursing Home ☐YES ☐NO	6. Telephone(Area Code/Number)

7. Prescribing Physician/ Practitioner Name and Address	10. Provider of Services(s) Name And Address
8. Medicaid Provider Number	9. Telephone (Area Code/Number)	8. Medicaid Provider Number	9. Telephone (Area Code/Number)

☐HOME HEALTH ☐PODIATRIST ☐OPTOMERIST ☐PHYSICAN ☐PSYCHOLOGIST ☐DME/OP ☐DDS ☐PHARMACY

DEPT USE ONLY

13. Authorization Period From: Through:	14. Description of Service(s) Required	15. Rec. Type	16. Ctgy. of Service
17. Primary Diagnosis Requiring Service(s)		18. ICD 9 CM	

19. Justification and Circumstances for Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

LINE NO. 20	21. Description of Procedures, Drugs, Equipment, or Other Services	22. Procedure/ Drug Code	23. Requested of Estimated Price Per unit	24. Bill Units	25. Months of Units of Service	26. Units per Claim Max. Min.	27. Max. units per month
1							
2							
3							
4							
5							
6							
7							
8							

	28. PROVIDERS SIGNATURE		29. Date Submitted
30. REQUEST ☐ Approved ☐ Approved As Amended ☐ Denied ☐ Pending /Additional Information	31. DMA SIGNATURE	32. DATE APPROVED / /

33. Explanation to Provider

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program

DMA 80 Rev. (7/10)

Figure 24: Prior Authorization Request Form (DMA-80)

PRIOR APPROVAL FOR MEDICAL SERVICES

MAIL COMPLETED FORMS TO:

GMCF
1455 Lincoln Pkwy, Suite 800
Atlanta, GA. 30346

Please provide written answers or check appropriate box. Type or print legibly. Where additional space is needed, please attach supplemental sheet(s).

1. PHYSICIAN'S NAME OR AGENCY NAME	2. PROVIDER #	3. ☐ M.D. ☐ D.O. ☐ D.P.M.
ADDRESS	TELEPHONE	

4. MEMBERS NAME	5. MEMBER ID NUMBER	6. SEX ☐ Male ☐ Female

7. ADDRESS	8. DATE OF BIRTH

9. HOSPITAL

10. DIAGNOSIS

11. DATE MEMBER FIRST SEEN FOR ABOVE DIAGNOSIS	12. MOST RECENT VISIT

13. MEMBERS PRESENT MEDICAL STATUS

14. TREATMENT OR SERVICES RENDERED

15. DATE AND RESULTS OF LAB PROCEDURES AND/OR X-RAYS

16. OPERATION, PROCEDURE, TREATMENT, OR SERVICE FOR APPROVAL Description	Procedure/Code	Estimated Price Per Unit	Units of Service
1			
2			
3			
4			

17. PLAN OF CARE

18. JUSTIFICATION FOR REQUESTING #16.

19. PHYSICIAN'S SIGNATURE	20. DATE
DATE	SIGNATURE

* Prior approval applies only to this member unless otherwise specified. The approval applies only if the member is eligible at the time the services are rendered.

**This request is subject to Retrospective Peer Review.

DMA 81 Rev. (07/10)

Figure 25: Prior Authorization Request Form (DMA-81)

C.2 Exceptional Transportation Prior Authorization Request Form (DMA-322)

The DCH guidelines set forth in the Policies and Procedures Manual, Part I, Section 203 and Part II, Chapter 800, of the Policies and Procedures for Exceptional Transportation Services manual discusses prior approval procedures and instructions for completing the form. DCH identifies services requiring prior approval.

When prior approval is requested, the coordinator of transportation services for DFCS or the non-emergency ambulance service provider must complete the Exceptional Transportation Prior Authorization Form, DMA-322.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
EXCEPTIONAL TRANSPORTATION
PRIOR AUTHORIZATION REQUEST*

Include this Number On All Claim Forms-----→	PRIOR APPROVAL NUMBER
Prior Approval Expires	

Mail Completed Forms To: GMCF, 1455 Lincoln Pkwy Suite 800, Atlanta, GA. 30346

Requested By:

1.TRANSPORTATION SERVICE PROVIDER NAME	2.PHONE (AREA CODE/NUMBER)
3.MAILING ADDRESS	

CITY	COUNTY	STATE	ZIP	4.PROVIDER MEDICAID NUMBER

Recipient Information:

5.RECIPIENT ADDRESS (LAST, FIRST, MIDDLE INITIAL)	6.RECIPIENT MEDICAID NUMBER

7. RECIPIENT ADDRESS	CITY	COUNTY	STATE	ZUP CODE

8.PHONE (Area Code/Number)	9.BIRTHDATE (MM/DD/YY)	10. AGE	11. SEX ☐Male ☐Female

12. DIAGNOSIS (If Known)

Health Care Provider Information:

13. HEALTH CARE PROVIDER NAME	14.PHONE (Area Code/Number)

15. HEALTH CARE PROVIDER ADDRESS	CITY	COUNTY	STATE	ZIP CODE

Description of Service:

16. TRANSPORTATION SERVICE(S) REQUESTED (CHECK ALL THAT APPLY)

☐ CODE T2003 – U1 AUTOMOBILE (1ST PSGR)
☐ CODE T2003 – U1 AUTOMOBILE (2ND PSGR)
☐ CODE T2003 – U1 AUTOMOBILE (3RD PSGR)
☐ CODE A0100 – TAXI
☐ CODE A0190 – U1 TAXI (Non-Local)
☐ CODE T2004 – CITY TRANSIT
☐ CODE T2001 – ESCORT
☐ CODE T2002 – OTHER
☐ CODE A0110 – COMMERICAL BUS OR TRAIN(INTERSTATE)
☐ CODE A0140 – AIRPLANE
☐ CODE A0170 – PARKING/TOLLS FEE

☐ CODE A0190 – Meals (MEMBER OUT-OF-STATE)
☐ CODE A0190 – U1 Meals (MEMBER IN-STATE)
☐ CODE A0180 – LODGING (MEMBER OUT-OF-STATE)
☐ CODE A0180 – U1 LODGING (MEMBER IN-STATE)
☐ CODE A0210 – MEALS (ESCORT OUT-OF-STATE)
☐ CODE A0210 – U1 MEALS (ESCORT-IN-STATE)
☐ CODE A0200 – LODGING (ESCORT OUT-OF-STATE)
☐ CODE A2000 – U1 LODGING (ESCORT IN-STATE)

17. CHECK ONE ☐ ONE WAY ☐ ROUND TRIP	18. CHECK ONE ☐ RECIPIENT ONLY ☐ RECIPIENT & ONE ESCORT

19. NO. OF TRIPS	20. NO. OF MILES	21. LENGTH OF STAY DAYS	22. DATE(S) OF SERVICE FROM: / / THROUGH / /	23. AMOUNT

24. CIRCUMSTANCES AND/OR JUSTIFICATION FOR REQUESTED SERVICES:

25. COMMENTS

DMA USE ONLY	26. APPROVED ☐	**OR**	27. DENIED ☐	28. REASON DENIED
	29. SIGNATURE			30. DATE	*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of Service.

DMA-322   Rev. (7/10)

Figure 26: Exceptional Transportation Prior Authorization Request Form (DMA-322)

Out-of-State Services
Request for Authorization

Required fields

Date of Request _____

*Member ID _____   Member Name _____

*Requesting Provider ID _____   Provider Name _____

*Provider Reference ID _____

Rendering Physician Information

*Out-of-State Provider Name _____   *Specialty _____

*Address 1 _____   *Phone _____ Ext _____

Address 2 _____   Fax _____

*City _____ *State _____ *Zip _____

Rendering Facility Information

*Out-of-State Facility Name _____   *Specialty _____

*Address 1 _____   *Phone _____ Ext _____

Address 2 _____   Fax _____

*City _____ *State _____ *Zip _____

Request Information

*Contact Name _____   *Contact Phone _____ Ext _____

Contact Fax _____   Contact Email _____

*Place of Service _____ Inpatient Hospital _____ Outpatient Hospital _____ Office

*Admission Type _____ Emergency _____ Elective

*Admit Date _____   *Discharge Date _____

*Release of Information Code   Plan Sponsor _____

Diagnosis (1 required)					Procedures			
ICD-9	ICD-9 Date	Primary?	Admission Diagnosis?		Procedure Code	From Date	To Date	Units

Send the following information with your request:

Letter of Medical Necessity should include:
Current Clinical Summary   Anticipated/scheduled date of service
Treatment Plan   Estimated length of treatment/stay
Reason for Out-of-State request
Additional medical documentation should include:
Pertinent past medical history/surgeries/treatments
Diagnostic reports supporting diagnosis
Indication that requested treatment/service is not available in Georgia
Psych/Social evaluation (if required)

PLEASE ATTACH ALL DOCUMENTATION THAT APPLIES

Figure 27: Out of State Services Request for Authorization

C.3 Medicaid Precertification Form

Completion of the Medicaid Precertification Form

The DMA-guidelines, set forth in chapter 800, of Part II Policies and Procedures for Hospital Services Manual, discuss precertification program requirements and procedures. Request for Medicaid precertification should be initiated at least one week prior to the planned admission or procedure. Precertification may be requested by contacting GMCF by any one of the following four methods: (1) telephone, (2) Web Portal, (3) fax, or (4) mail. When using either fax or mail, the Medicaid Precertification Form must be completed as follows:

Mail the completed form to:

Georgia Medical Care Foundation

Medicaid Precertification Department

1455 Lincoln Parkway, Suite 750

Atlanta, GA 30346

Fax the completed form to: 1-678-527-3003

Please request this form from HP Enterprise Services.

This form is used to submit requests to the Georgia Medical Care Foundation (GMCF) for precertification.

Figure 29: Medicaid Precertification Form

Out-of-State Services
Request for Authorization

* Required fields

Date of Request _____

*Member ID _____   Member Name _____

*Requesting Provider ID _____   Provider Name _____

*Provider Reference ID _____

Rendering Physician Information

*Out-of-State Provider Name _____   *Specialty _____

*Address 1 _____   *Phone _____ Ext _____

Address 2 _____   Fax _____

*City _____ *State _____ *Zip _____

Rendering Facility Information

*Out-of-State Facility Name _____   *Specialty _____

*Address 1 _____   *Phone _____ Ext _____

Address 2 _____   Fax _____

*City _____ *State _____ *Zip _____

Request Information

*Contact Name _____   *Contact Phone _____ Ext _____

Contact Fax _____   Contact Email _____

*Place of Service _____ Inpatient Hospital _____ Outpatient Hospital _____ Office

*Admission Type _____ Emergency _____ Elective

*Admit Date _____   *Discharge Date _____

*Release of Information Code _____ Plan Sponsor

Diagnosis (1 required)			Admission Diagnosis?		Procedure Code	Procedures		
ICD-9	ICD-9 Date	Primary?				From Date	To Date	Units

Send the following information with your request:

Letter of Medical Necessity should include:

Current Clinical Summary   Anticipated/scheduled date of service
Treatment Plan   Estimated length of treatment/stay
Reason for Out-of-State request

Additional medical documentation should include:

Pertinent past medical history/surgeries/treatments
Diagnostic reports supporting diagnosis
Indication that requested treatment/service is not available in Georgia
Psych/Social evaluation (if required)

PLEASE ATTACH ALL DOCUMENTATION THAT APPLIES

Figure 30: Out of State Services Request for Authorization

C.4 Medically Needy Spenddown Form (DMA–400)

The DMA-400 form is completed by DFCS for services rendered to medically needy members on the same date as the beginning date of eligibility. The form identifies the spenddown amount of first day liability, which is payable to the provider by the member.

What is the Medically Needy Spenddown Program?

The Medically Needy program covers children under age eighteen, pregnant women, aged, blind, and disabled persons who otherwise are not Medicaid eligible because of income. Their monthly income may exceed the Medicaid payment income eligibility standard and would result in these individuals having to pay for a prescribed amount of their healthcare before they are eligible for Medicaid.

**MEDICALLY NEEDY FIRST DAY LAIBILITY
AUTHORIZATION FOR REIMBURSEMENT**

Patient Name: _____

Patient ID Number: _____

Beginning Date of Eligibility (Begin Authorization Date): _____

Provider Name: _____

Bill to be Processed with Client Liability for Beginning Date: ☐ Yes   ☐ No

If yes, the amount the Client is responsible for paying to the Provider names above is
$ _____
(Applicable to covered services rendered by Medicaid-enrolled providers)

Payment is made only to Medicaid-enrolled providers for covered expenses. Services not covered by Medicaid or services rendered by a provider who is not Medicaid-enrolled must be paid by the member.

_____   _____
DATE   EW SIGNATURE

_____   _____
CASE NUMBER   COUNTY DEPARTMENT OF FAMILY AND CHILDREN
                                                                 SERVICES

Please mail this form to:

**GHP
P.O. Box 105208
Tucker, Ga. 30085-5208**

DMA 400 (Rev 07/10)

Figure 31: Medically Needy Spenddown Form (DMA–400)

If the statement on the DMA-962 form reads, "DMA-Form 400 required" and if the beginning date of eligibility is equal to the DOS or within the span of dates of service, the DMA-400 form must be attached to the submitted claim for payment. If not attached, the claim is rejected or denied to the provider, with an error message stating that the DMA-400 form is required before the claim can be processed.

The DMA-400 form is completed by DFCS for services rendered to Medically Needy Members on the same date as the beginning date of eligibility. The form identifies the spenddown amount of first day liability, which is payable to the provider by the member.

This amount could be zero; however, the paper DMA-400 form must be submitted for payment.

Note: Do not deduct the first day liability amount that appears on Form 400 from submitted charges. If you have any questions about eligibility or the DMA-400 form, contact the member or your county DFCS office.

C.5 Certification of Necessity for Abortion Form (DMA-311)

The Certification of Necessity for Abortion form is required when filing a claim for an abortion procedure and should be submitted as a hard copy with the appropriate supporting documentation.

CERTIFICATE OF NECESSITY FOR ABORTION (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse *only* for abortion which meet the criteria established in Part II, Chapter 900 of the *Policies and Procedures for Physician Services* manual.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

MEMBER INFORMATION

NAME _____

MEDICAID # _____

ADDRESS _____

STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

❏ This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place this woman in danger of death unless an abortion is performed.

❏ The pregnancy is the result of rape.

❏ The pregnancy is the result of incest.

_____ , M.D.
(Print Name)

_____ , M.D.
(Signature of Physician)

DMA-311 (Rev. 3/03)
746-311

(ATT 12)

Figure 32 Certification of Necessity for Abortion Form (DMA-311)

C.6 Informed Consent for Voluntary Sterilization Form (DMA-69)

This form is required whenever submitting a claim for voluntary sterilization and should be submitted as a hard copy with the appropriate supporting documentation. For specific instructions on completing the sterilization form, please refer to the Part II Policy and Procedures Manual.

Figure 33: Informed Consent for Voluntary Sterilization Form (DMA-69)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed this consent form, I explained to him/her the nature of the
Name Of Member

sterilization operation, _____ , the fact that it is intended to be a final and
Sterilization Procedure

irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different be-
cause it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided
by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily
requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
Signature Of Person Obtaining Consent

_____
Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on
Name of Member

_____ , I explained to him/her the nature of the sterilization operation
Date Of Operation

_____ , the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure

the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different be-
cause it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided
by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily
requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days
after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used.

(1)   At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2)   This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the
following circumstances (check applicable box and fill in information requested):

☐   Premature delivery
Individual's date of expected delivery _____

☐   Emergency abdominal surgery (describe circumstances): _____

_____

Physician's Signature _____ Date _____

DMA-69 (04/03)

Figure 34: Informed Consent for Voluntary Sterilization Form (DMA-69)

C.7 Acknowledgement of Prior Receipt of Hysterectomy Information Form (DMA-276)

This form is required for every hysterectomy procedure and should be submitted as a hard copy with the appropriate supporting documentation. For specific instructions on completing the sterilization form, please refer to the Part II Policy and Procedures Manual.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Medicaid Program

RECEIPIENT INFORMATION

RECIPIENT NAME: LAST   FIRST   INITIAL   SUFFIX

RECIPIENT MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section 1— Recipient's Statement

I have been told and I under that this hysterectomy (operation to remove my womb uterus) will cause/has caused me to be permanently sterile (unable to bear children).

_____   _____
Signature of Medicaid Recipient   Date

OR

_____   _____
Signature of Recipient   Date

STATEMENT OF MEDICAL NECESSITY

Section II – Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable**. – (Recipient's signature not required if number 1 or 2 is applicable.)

1. Recipient was sterile prior to hysterectomy. The recipient was sterile because _____

_____

_____

2. Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

_____
Physician's Name (Please print)

_____   _____
Physician's Signature   Date

DMA 276 (Rev. 4/03)

Figure 35: Acknowledgement of Prior Receipt of Hysterectomy Information Form (DMA-276)

C.8 Hospice Referral Form DMA-521

HOSPICE REFERRAL FORM
FOR
NON-HOSPICE RELATED SERVICES

SECTION I – TO BE COMPLETED BY THE PROVIDER

1. _____   2. _____
   Member Name   Address

3. _____   4. _____
   Medicaid Number   Social Security Number

5. _____   6. _____
   Hospice Name   Hospice Address & Phone #

7. _____   8. _____
   Provider Name   Provider Medicaid #

9. _____
   Provider Address & Phone Number

10. Type of Service: ☐ Inpatient   ☐ Physician   ☐ Other
                      ☐ Outpatient ☐ DME   _____
                      ☐ Emergency   _____

11. Non-Hospice Related Diagnosis Condition: _____
    _____

12. Hospice Diagnosis: _____
    _____

- -

SECTION II – TO BE COMPLETED BY DMA

Date Request for Additional Documentation: _____

Approval/Denial Date _____ Analyst Signature _____

DMA 521 Rev. (7/10)

Figure 36: Hospice Referral Form DMA-521

C.9 Mailroom Return To Provider Letter

Figure 37: Mailroom Return To Provider Letter

C.10 Request for Forms

GEORGIA HEALTH PARTNERSHIP

Request for Forms

Instructions:
- Quantity – Indicate quantity requested in the **Quantity Ordered** column.
- Shipping Address – Type or print your GHP provider number, provider name, and address in the **FROM** box.

NOTE: We must have a **STREET ADDRESS**; UPS will not ship to a post office box.

Mail this form to: – GHP, P. O. 105209, Tucker, GA 30085-5209

Item	Form Type	Qty Ordered
DMA-6	Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded	
DMA-44	Home Health Patient Profile	
DMA-59	Authorization for Nursing Facility Reimbursement	
DMA-69	Informed Consent for Voluntary Sterilization	
DMA-80	Prior Authorization Request	
DMA-81	Prior Approval for Medical Service	
DMA-276	Statement of Medical Necessity	
DMA-311	Certification of Necessity for Abortion	
DMA-380	Optical Device Prescription	
DMA-410	Third Party Liability (TPL) Confirmation Statement	
DMA-501	Adjustment	
DMA-520	Provider Inquiry Form	
DMA-520A	Provider Inquiry Form for Medical Claims and PA/UM	
DMA-521	Hospice Referral Form for Non-Hospice Related Services	
DMA-550	Newborn Medicaid Certification	
DMA-610	Prior Authorization Request	
DMA-613	Level I Applicant/Resident I.D. Screening Instrument	
DMA-615	ESRD Enrollment Application	
DMA-632	Presumptive Eligibility Determination for Pregnancy-Related Care	
DMA-633	Change Form /Temporary Medicaid Card	
DMA-634	Notice of Action	
DMA-635	Post Partum Home Visit Mother Assessment	
DMA-637	Post Partum Teaching Guide	
DMA-638	Letter of Understanding	
DMA-639	Model Waiver Assessment	
DMA-641	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (6-7 month visit)	
DMA-642	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (11-12 month visit)	

FROM		
	Provider Medicaid ID Number (10-digits):	
	Provider Name:	
	Street Address:	
	City, State, Zip Code:	

DMA 292   Rev. (07/10)

Figure 38: Request For Forms

C.11 Attachment Form for Electronically Submitted Claims

Most attachments for Web Portal claims can be attached using the Web Portal. If unable to submit attachments electronically, providers should use the following form when using one of the methods below:

1.   Provider Electronic Solutions (PES) software

2.   Remote Access Server (RAS) for dial-up

3.   Diskette/CD-ROM/tape

4.   DVD

5.   Value Added Network (VAN)

Figure 39: Attachment Form for Electronically Submitted Claims

Appendix D Attachment Codes

Effective November 1, 2010, the following HIPAA attachment codes have replaced the previous attachment codes that were being assigned to those claims that required an attachment for claims' processing. The "Old Attachment Code" column identifies those attachment codes previously used. "HIPAA Attachment Codes" column identifies the replaced attachment codes. Also included in this column is a brief description of the HIPAA attachment code. The "Comments" column explains the type of attachment that is not self-explanatory and need further clarification.

Attachment Codes Crosswalk

Old Attachment Code	HIPAA Attachment Code	Comments
04	AS Admission Summary	History & Physical or progress notes
05		
12		
04	B3 Physician Order	
21	B4 Referral Form	Hospice Referral form, Revocation Form, Election Form, Hospice Discharge Form, Hospice Transfer Form, Hospice Physician Certification and Recertification Form
01	CT Certification	DMA-964, DMA-400 (DFCS issued letter), Temporary Medicaid Certification Form, Supplemental Security Income Letter, DMA-304, Death Certificate
05		
12		
14		
21		
04	DA Dental Models	
04	DS Discharge Summary	
05		
12		
06	EB Explanation of Benefits	EOMB, TPL, Remittance Advice
09		
11		

Old Attachment Code	HIPAA Attachment Code	Comments
04	NN Nursing Notes	
04	OB Operative Notes	
05		
12		
04	OZ Support Data for Claim	This can be any miscellaneous documentation needed to support processing a claim
05		
12		
21		
04	RB Radiology Films	
04	RR Radiology Reports	
04	RT Report of Test and Analysis	
Note: If you are unable to find the appropriate attachment code for documentation being submitted as an attachment, please use "OZ".		

Glossary

270/271 (*Eligibility/Benefit Inquiry/Response):* The Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine: a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and b) the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits. These are X-12 transactions mandated by HIPAA regulations.

276/277 (*Claim Status Request/Claim Status Response):* The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following: a) a solicited response to a health care claim status request (276), b) a notification about health care claim(s) status, including front end acknowledgments, or c) a request for additional information about a health care claim(s). The 276 is used only in conjunction with the 277 Health Care Claim Status Response. These are X-12 transactions mandated by HIPAA regulations.

277 (*Unsolicited Claim Status):* The Unsolicited Claim Status (277) transaction set can be used to transmit an unsolicited notification about a health care claim status. This is an X-12 transaction mandated by HIPAA regulations.

820 (*Premium Payment):* The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium remitter can be: a) an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer, b) a government agency paying health care premiums, or c) an employer paying group premiums. The premium receiver can be an insurance company, a government agency, or a health care organization. The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH (Automated Clearing House) Network to facilitate both the remittance and dollars movement. This is an X-12 transaction mandated by HIPAA regulations.

834 (*Enrollment/Maintenance):* The 834 is used to transfer enrollment information from the sponsor, the party that ultimately pays for the coverage, benefit, or policy to a payer, the party that pays claims and/or administers the insurance coverage, benefit, or product. This is an X-12 transaction mandated by HIPAA regulations.

835 (*Payment Advice):* The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI (Depository Financial Institutions) take funds from the payer's account and transfer those funds to the payee's account. This is an X-12 transaction mandated by HIPAA regulations.

837 (*Dental/Professional/ Institutional Claim):* The Claims/Encounters (837) is intended to originate with the health care provider or the health care provider's designated agent. The 837 provides all necessary information to allow the

destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). This is an X-12 transaction mandated by HIPAA regulations.

997 (*Functional Acknowledgement*): The Functional Acknowledgement is generated by the receiver of an 837 and is used to notify the sender that the acknowledged transaction has been: a) accepted, b) rejected, c) accepted with errors, or d) partially accepted. This is an X-12 transaction mandated by HIPAA regulations.

A

ABANDONED CALL: A call is considered abandoned if the caller is connected to the system but hangs up before being connected with an agent or informational announcement. Also known as a lost call.

ABR: Automatic Backup and Recovery.

ABD: Aged Blind and Disabled.

ACCEPTED CLAIM: Any claim for services rendered that has passed clerical and machine edits, resulting in a claim that can be accepted for adjudication.

ACCESS CONTROL FACILITY (ACF2) : Mainframe security for MMIS. ACF2 for CICS includes security by individual, location, files, and fields.

ACCESS CONTROL FACILITY/MULTIPLE VIRTUAL STORAGE (**ACF/MVS) :** A Security Extension to the IBM Multiple Virtual Storage Operating System (MVS OS).

ACCOMMODATION: A hospital room with one or more beds.

ACCOMMODATION CHARGE: A charge billed on inpatient hospital claims for bed, board, and nursing care (revenue codes 100-219).

ACCOUNTS RECEIVABLES (AR, A/R) : Money owed to the State by a provider, beneficiary, insurance company, drug manufacturer, etc.

ACCRETION: A process that occurs when a beneficiary is eligible for coverage under both Medicaid and Medicare. Medicaid pays the beneficiary's Medicare premium, thus buying into the Medicare Program.

ACF: Advanced Communications Function.

ACG: Ambulatory Care Grouper.

ACTUAL CHARGE: A charge made by a physician or other supplier of medical services and used in the determination of reasonable charges.

ACTUAL DAMAGES: Damages that can be measured in actual cost.

ACUTE CARE: Medical treatment rendered to individuals whose illnesses or health problems are of a short term or episodic nature. Acute care facilities are those hospitals that serve mainly persons with short term health problems.

AD HOC REQUEST: A request to provide non-production support. This support may be in the form of one-time updates to production files or the creation of specific one-time or as needed output reports.

ADA: Americans with Disabilities Act.

ADJUDICATE (CLAIM) : The adjudication process occurs during claims processing to determine the disposition of a claim (paid or denied). A claim passes through all the edit and audit criteria until it is determined whether all program requirements have been met and whether the claim is to be paid or denied.

ADJUDICATED CLAIM: A claim that has moved from pending status to final disposition, either paid or denied.

ADJUDICATION CYCLE: This cycle refers to the daily or daily/weekly claims processing cycles that are known as the system processing of claims to the point where a decision has been made to pay, deny, or suspend the claim.

ADJUSTMENT: A transaction that changes any information on a claim which has been paid.

ADJUSTMENT PROCESSING: A batch process that sends a file of adjustment request records to the Financial Subsystem for incorporation into the claims processing cycle.

ADJUSTMENT REASON CODES (PRIMARY AND SECONDARY) : The adjustment reason codes specify why the initial adjustment took place, whereas the secondary adjustment reason indicates the second adjustment occurrence on a claim. These codes are also known as the primary reason and the secondary adjustment reason.

ADMINISTRATIVE FEE: The operations fees being charged to DCH on the Contractor monthly invoice

ADMISSION: The first day on which a patient is furnished inpatient hospital or extended care services by a qualified provider.

ADA: American Dental Association The national professional association for dentists.

ADP: Automated Data Processing.

ADR: Address.

ADVANCE – MANUAL: Advance payment issues as a manual check to be picked up by the provider or sent via Federal Express

ADVANCE – SYSTEM: Advance payment issues through the system and included in the regular payment cycle

AFDC: Aid for Families with Dependent Children. This federal program was replaced by Temporary Assistance to Families in Need of Services (TANF).

AICPA: American Institute of Certified Public Accountants.

AID CATEGORY: Program category under which a beneficiary can be eligible for Medicaid.

AID CODE: A designation of the type of benefits for which a Medicaid beneficiary is eligible.

AIMS: Aging Information Management System.

ALERTS: A message related to a supervisors or system managers. Alert messages include error messages and emergency warnings.

ALLOWABLE COSTS: The maximum dollar amount assigned for a particular procedure based on various pricing mechanisms. Medicaid reimburses hospitals for certain, but not all costs. Excluded costs include non-covered services, luxury accommodations, and unnecessary and unreasonable costs.

ALLOWED AMOUNT: Either the amount billed for a medical service or the amount determined payable by the State, whichever is the lesser figure.

ALPHANUMERIC: The use of alphabetic letters mixed with numbers and special characters as in name, address, city, and state.

AMA: American Medical Association. The national professional association of physicians. This organization publishes the highly utilized CPT-4 books.

ANCILLARY CHARGE: A charge used only in institutional claims for any item except hospital and doctor fees (examples include drug, laboratory, and x-ray charges).

ANCILLARY SERVICES: Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.

ANSI: American National Standards Institute. In computer programming, ANSI most often denotes the standard versions of C, FORTRAN, COBOL, or other programming languages. ANSI-standard escape sequences control computer screens; whereas ANSI extended character set used in Microsoft's Windows products includes all of the ASCII characters.

APD: Advanced Planning Document. Federal budget request document that a state must submit to CMS in order to receive enhanced federal funding for Medicaid systems or operations.

APPROVE: A clear, written expression issued by DCH indicating that Contractor's performance or deliverable is satisfactory under the terms of the Contract.

ARCHIVE: A copy of data on disks, CD-ROM, magnetic tape, etc., for long-term storage and later possible access. Archived files are often compressed to save storage space. (Imaging.)

ASA: Average Speed of Answer.

ASCII: American Standard Code for Information Interchange

The most popular coding method used by small computers for converting letters, numbers, punctuation and control codes into digital form. Once defined, ASCII characters can be recognized and understood by other computers and by communications devices. ASCII represents characters, numbers, punctuation marks or signals in seven on-off bits. Capital "C", for example, is 1000011, while "3" is 0110011. This compatible coding allows all PCs to talk to each other, if they use a compatible modem or null modem cable and transmit and receive at the same speed. (Imaging.)

ASO: Administrative Services Organization. An organization contracted to perform functions such as provider and member profiling, case management, disease and care management, nurse call line, enhanced prospective medical review, added fraud and abuse detection, certain eligibility functions and level of care determination for Members where risk based care is not feasible.

ATN: Application Tracking Number. The unique number given to a provider application in the Provider subsystem.

ATR: Accounting Transaction Request. Document used to request HP Enterprise Services create Gross Level AR, Gross Level Payouts, Withholdings, voiding of checks, Recoupment changes, from DCH.

ATTRIBUTE: Additional fields of information that are required for some call control commands within the telephone system. When you enter a command in a Call Control Table that requires attributes, these fields appear in the table to the right of the command name.

ATTRIBUTE: In graphics, the condition a font is in (boldface, italic, underlined, reverse video) is its attribute. In a document retrieval system, an attribute of a file is one of the keys by which the document has been stored and indexed. (Imaging.)

AUDIT: Limitations applied to specific procedures, diagnoses or other data elements after editing and validation of the claim to ensure conformity and consistency of claim payment.

AUTHENTICATION: A query method that ensues that both the sender and receiver of an electronic message are valid and are authorized to transmit and receive messages.

AUTO ASSIGNMENT: An automated process used to make 'intelligent' Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord.

AUTOMATIC RECOUPMENT: Automatic recoupment occurs when an A/R with a credit balance has recoupments applied to it by adjustments or new-day claims.

Money is recouped only through the payment process, which is automatic, and cannot be posted online with a refund.

AVAYA CALL MANAGEMENT SYSTEM (ACMS) : Avaya Definity 75 G3r-V9 telephone system provides information and management tools to help monitor and analyze the performance of the call center operation.

AVRS: Automated Voice Response System. (See IVR for definition.)

B

BACKUP: Duplicate copy of data placed in a separate, safe place - electronic storage, on a tape, on a disk, in a vault - to guard against total loss in the event the original data somehow become inaccessible. Generally for short-term safety. Contrast with archive, which is a filed-away record of data meant to be maintained a long time, in the event of future reference. (Imaging.)

BBA: Balanced Budget Act of 1997.Federal legislation enacted in 1997 that gave beneficiaries certain rights related to Managed Care enrollment and disenrollment. Most significant changes in the Medicaid/Medicare Program since their inception. Provides for state option to use Managed Care. Provides that an MMIS must be compatible with Medicare claims processing and must, after January 1, 1999, transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).

BATCH: A set of claims. Paper claims are batched by invoice type, e.g., UB-04, HCFA-1500, pharmacy, adjustments, etc. The number of claims in a paper batch may vary from 1 to 99. Electronic batches have no claim ceiling, but must contain at least 25 claims. Claims are batched to control the quality and quantity of claims entered into the system. Batching supports the assignment of a unique set of numbers to a specific set of claims. There are specific batch number ranges for certain batch types: EMC, adjustments, credits, POS transactions, etc.

BATCH CYCLE: Batch cycles are scheduled and managed by the Autosys job scheduling software. Processing from all the subsystems, and claim adjudication is done at this time. Many edits and parameters are used for a batch cycle.

BATCH PROCESSING: One of the non-interactive computer processes used in the MMIS. In batch processing, the user gives the computer a "batch" of information; the computer then processes it as a whole. Batch processing contrasts with interactive processing, in which the user communicates with the computer by means of a workstation while the program is running.

BATCH REQUEST: A batch request does not require immediate processing. The requester does not wait for the request to be completed, and it does not receive a success or failure response back from the unite storager. (Imaging.)

BIAR: Business Intelligence and Analytical Reporting.

BENCHMARK: A level of care set as a goal to be attained. For example, competitive benchmarks are comparisons with the best external competitors in the field. The

State Children's Health Insurance Program benefit package includes a benchmark package that is used to compare other benefit packages' value and comprehensiveness.

BENDEX: Beneficiary and Earnings Data Exchange System. A file containing data from the federal government regarding all persons receiving benefits from SSA and the Veterans Administration.

BENEFIT PLAN: A group of covered services (benefits) that are granted to a beneficiary who is deemed eligible for the program the benefit plan represents.

BENEFITS: The process whereby a State pays for medical services rendered to Medicaid-eligible beneficiaries.

BILLED AMOUNT: The billed amount is the dollar figure submitted by a provider for medical services rendered.

BIN: Bank Identification Number.

BITMAP: Representation of characters or graphics by individual pixels, or points of light, dark or color, arranged in row (horizontal) and column (vertical) order. Each pixel is represented by either one bit (simple black and white) or up to 32 bits (fancy high definition color). (Imaging.)

BRIGHTNESS: The balance of light and dark shades in an image. Contrast with contrast. (Imaging.)

BROKER: The contracted Vendor which is responsible for the Non-Emergency Transportation (NET) Program. (See definition of NET.)

BRS: Benefits Recovery Section. The Unit at DCH responsible for addressing accounts receivables, liens, recoupments, refunds, etc.

BULLETINS: Directives mailed, emailed, uploaded to the Web Portal to Georgia Medical Assistance Program providers containing information on policy, billing procedures, benefits and limitations, etc.

BUNDLED CHARGES: Charges that are combined together or represent a flat rate such as in capitated reimbursed where there would be a specified fee for a service. In an example of a surgery procedure, the bundled charges would include supplies, surgery charges, anesthesia charges, recovery, etc. In contrast, unbundled charges would be separate charges for each entity.

BUSINESS ASSOCIATES: Person or organization that performs a treatment, payment, or health care operations function or activity on behalf of a covered entity.

BUSINESS DAY Any day the State is open for normal business operations.

BUSINESS PRACTICE MANUAL (BPM) : The Fiscal Agent internal user manuals.

BUY-IN: Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid beneficiaries, enrolling them in Medicare Title XVIII Part A and/or Part B program.

BYTE: Common unit of computer storage. A byte is eight bits of information, one of which may be a parity bit. Generally, eight bits equals one character. Also called 'octet'. (Imaging.)

C

CACHE: (Pronounced "cash") Small portion of high-speed memory used for temporary storage of frequently used data. Reduces the time it would take to access that data, since it no longer has to be retrieved from the disk. (Imaging.)

CARRIER: A carrier refers to a private insurance company.

CASE NUMBER: The number assigned to each Medicaid case opened by DFACS.

CATEGORICALLY NEEDY: The term that identifies those aged, blind or disabled individuals or families who meet Medicaid eligibility criteria and who meet the financial limitation requirements for TANF, SSI or optional State financial support.

CCB: Change Control Board, a formally constituted group of DCH staff responsible for approving or rejecting changes to the source code, run-time files, documentation, configuration files and installation scripts that comprise the Proprietary and Non-Proprietary Software.

CCN: Cash Control Number. This is the unique number assigned to a Cash Receipt.

CCP: Change Control Process. This is the process used to review, escalate, and dispose (approved or denied) any necessary changes made to project requirements.

CERTIFICATION: This review is conducted in response to a State's request for 75 percent Federal Financial Participation (FFP), to ensure that all legal and operational requirements are met by the MMIS system and its components.

CERTIFICATION DATE: An effective date specified in a written approval notice from CMS to the State when 75 percent FFP is authorized for the administrative costs of an MMIS.

CFR: Code of Federal Regulations. A codification of the general and permanent rules published in the federal register by the Executive departments and agencies of the federal government.

CHANGE CONTROL: The exercise of authority over changes to configuration items, including impact analysis, prioritizing, granting access, signing out, approving or rejecting, capturing change contents, and adding.

CHARACTER RECOGNITION: The ability of a machine to read human-readable text. (Imaging.)

CHARACTER VALIDATION: As each character is entered by the data capture team member, its validity is checked and the character is corrected, if necessary. (Imaging.)

CGI: Common Gateway Interface. One of the most common ways to add programs or scripting languages that execute on the server to your Web-based applications.

CIS: Children's Intervention Services.

CISS: Children's Intervention School Services.

CLAIM: A request for payment filed with the fiscal agent, on a form prescribed by DCH and the fiscal agent, by a certified Medicaid provider for Medicaid-covered medical and medically related services rendered on behalf of an eligible Medicaid beneficiary.

CLAIM TYPE: The classification of a claim by origin or type of service provided to a beneficiary.

CLAIM HISTORY: All claims processed in the MMIS are kept available in the system and are referred to as being "in history."

CLEAN CLAIM: See "Accepted Claim."

CLERK ID: A code assigned to personnel involved with processing records in the MMIS claims processing system.

CLIA: Clinical Laboratory Improvement Amendments.

CMMI: Capability Maturity Model Integration.

CMO: Care Management Organization.

CMS: Centers for Medicare and Medicaid Services. The federal agency (formerly known as HCFA) responsible for the administration of the Medicaid, Medicare, and other health care programs.

CMS 1500: The claim form used by DCH to file for services performed by most practitioners.

CO: Change Order. The documentation of a modification to the transfer system. A change order is not a modification of a requirement; it is the modification of the base system to meet an existing requirement.

COB: Coordination of Benefits.

COE: Category of Eligibility or Aid Category.

COINSURANCE: An arrangement by which an insurance plan, Medicare, Medicaid or other third party share the cost of medical expenses.

COMMUNICATION PROTOCOL: Establishes the communication parameters between two computers. Includes baud rate, type of transmission, and parity setting.

COMMUNICATIONS: The means of electronically linking two computers to exchange information in EDI.

COMMUNICATION SOFTWARE: Software necessary to add appropriate protocols to the EDI documents in preparation for transmission over a telecommunications network.

COMPANION DOCUMENTS: A guide of Georgia specific information to be used in coordination with the Implementation Guide for X12 and NCPDP formatting.

COMPLAINT: A relatively minor verbal or written expression of concern about a situation that can be resolved on an informal basis.

COMPLIANCE CHECKING: A validation check to ensure that a transmission contains the minimum mandatory information required by the EDI standard.

CONTACT A record of an interaction between a customer (provider or member) and a system user.

CONTRACT: The written, signed agreement resulting from this RFP.

CONTRACT MANAGER: Person or entity designated by DCH as the chief point of contact for communications with DCH for the Operations Phase. Provides project direction and monitors the activities of the contract.

COS: Category of Service. This would relate to the provider contract in HP Enterprise Services.

COST AVOIDANCE: A claim may be denied when coverage exists and there is no indication that the carrier has been billed (cost avoided).

COST SHARE: The amount that a member receiving services under CCSP or an HCBS waiver may be required to pay toward the cost of reimbursement for services received.

COTS: Commercial Off-the-Shelf Software.

CPT: Common Procedural Terminology. A unique coding structure scheme for all medical procedures approved by the American Medical Association.

CROSSOVER CLAIM: A claim for services rendered to a member eligible for benefits under both Medicaid and Medicare programs. Medicare benefits must be processed prior to Medicaid benefits.

CROSS WALK: A table used to one code to another code.

CSR: Customer Service Request.

CTMS: Contact Tracking Management Solution. This ancillary application provides a means of access and storage for all information associated with a customer service contact. All contact information is associated with an assigned CTN. This information includes contact type, demographic information, questions, resolutions, and contact reasons. HP Enterprise Services and DCH staff enter information for each contact through online windows. Search windows allow users to sort and access contacts based on a variety of criteria. Reports are available based on open dates, status, clerk IDs and department.

Example:

Item: Written Correspondence

Details of the written correspondence are stored within CTMS

Actual process of where the written correspondence goes is Workflow

CTN: Contact Tracking Number. A unique number used in CTMS.

CUSTOMARY CHARGE: A dollar amount that represents the median charge for a given service by an individual physician or supplier.

CUSTOMIZATION: Process of building or modifying an instrumentality in accordance with the State of Georgia, Department of Community Health's specification.

CYCLE: A single event that is repeated, for example, in a carrier frequency, one cycle is one complete wave. Or, a set of events that is repeated, for example, in a polling system, all of the attached terminals are tested in one cycle.

D

DATA: Individual facts, statistics or items of information.

DATABASE (DB): Data that has been organized and structured in a disciplined fashion, so that access to information of interest is as quick as possible. Database management programs form the foundation for most document storage indexing systems. (Imaging.)

DATABASE ADMINISTRATOR (DBA) : The person responsible for maintaining the database system: managing data, designing database objects, database performance and data recovery and integrity at a physical level. This person is not an applications programmer.

DATABASE TABLE: A collection of similar records in a database within the telephone system. The Call Center software uses database tables to store all types of user-entered information. For example, the User table contains one record for each user in the system. The Agent Group table defines each agent group and sets options for each. All tables in the system database are accessed through the Database command on the Call Center main menu.

DATA CAPTURE: Entering data into the computer, which includes keyboard entry, scanning and voice recognition. When transactions are entered after the fact (batch data entry), they are just stacks of source documents to the keyboard operator. Deciphering poor handwriting from a source document is a judgment call that is often error prone. Online data capture team members, in which the team member takes information in person or by phone, entails interaction and involvement with the transaction and less chance for error.

DB2: Database 2.

DDI: Design, development, and implementation.

DCH: State of Georgia, Department of Community Health.

DCN: Document Control Number. A unique number assigned to each document as it is imaged.

DDI: Refers to the Design, Development and Implementation activities of the contract.

DED: Data Element Dictionary. Describes the fields (data elements) within a database.

DEDUCTIBLE: The amount of expense a member must pay before Medicare or another third party begins payment for covered services.

DEERS: Defense Enrollment and Eligibility Reporting System. A system that contains eligibility information on CHAMPUS, the insurance company for military dependents.

DELIMITER: A special character used to separate fields of data. The three used in an EDI file are the segment delimiter, the element delimiter, and the sub-element delmiter.

DENIED CLAIM: A claim for which no payment is made to the provider because the claim is for non-covered services, an ineligible provider or member, is a duplicate of another transaction, contains invalid information, or is missing required information.

DENTAL CLAIM: A claim filed for payment of dental services. A claim is filed: (1) for dental screening for children, (2) for one or more services given on a single day, or (3) upon completion of service for a condition. The claim is filed on the American Dental Association claim form or HIPAA-compliant electronic claim format.

DENTAL SERVICES: Any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. These services may include treatment of teeth and associated structures of the oral cavity and treatment of disease, injury, or impairment that may affect the oral or general health of the individual. Services are subject to the limitations established under the Georgia Medicaid program.

DEPARTMENT ID: Field that categorizes a transaction as Aged Blind and Disabled (ABD), Low Income Medicaid (LIM), or PeachCare (PCK). Dept ID for claims is derived from the COE and is drop down field for gross level payouts and receivables. Also uses COS to determine final value on the accounting interface.

DESKTOP IMAGING SYSTEM: An imaging system with a single workstation (often a microcomputer) meant to be used by only one person at a time. (Imaging.)

DFCS: State of Georgia, Department of Human Services Division of Family and Children Services

DHHS: United States Department of Health and Human Services.

DHS: State of Georgia, The Department of Human Services.

DIAGNOSIS CODE (DIAG, DX) : The medical classification of a disease or condition according to ICD-9-CM or HCPCS. A numeric code that identifies the patient's condition as determined by the provider of the performed service.

DISPOSITION (CLAIMS): The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the Exception Control File.

DISPOSITION (FINANCIAL): The posting of a receipt against a payee gross level AR or claim AR, gross level of the receipt, or refunding of the receipt.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM: A federal program that works to increase health care access for the poor. Hospitals that treat a disproportionate number of Medicaid and other indigent patients qualify for DSH payments through the Medicaid program based on the hospitals' estimated uncompensated cost of services to the uninsured.

DME: Durable Medical Equipment.

DMO: Disease Management Organization.

DOAS: Department of Administrative Services, State of Georgia.

DOB: Date of Birth.

DOCUMENT: Structured file sent to a trading partner. In ASC X12 usage, a document is synonymous with a transaction set.

DOCUMENT IMAGES: A computerized representation of a picture or graphic. (Imaging.)

DOCUMENT RETRIEVAL: The ability to search for, select and display a document or its facsimile from storage. (Imaging.)

DR: Disaster Recovery. Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss.

DRA: Deficit Reduction Act.

DRG: Diagnosis-Related Group. DRGs are the basis for one type of hospital reimbursement. A hospital specific fee is calculated for each diagnosis group for each hospital. Factors of age, sex, length of stay data, and historical costs for each hospital are taken into consideration in calculating the reimbursement amount. Usually, mental institutions and pediatric hospitals are excluded from DRG reimbursement due to the abnormal length of stay experienced by most patients.

DSD: Detailed System Design. Document created by the Fiscal Agent as a detailed guide to developing a new system or subsystem.

DSM: The Georgia Disease State Management Enhanced Care program administered by contracted Disease Management Organizations.

DSM III: Diagnostic and Statistical Manual for Mental Disorders, Third Edition, Revised. A publication of the American Psychiatric Association establishing a coding system for mental diagnoses.

DSS: Decision Support System.

DUPLICATE CLAIM: A claim that is either a total or partial duplicate of services previously paid. It is detected by comparing a new claim to processed claims history files.

DUPLICATE PAYMENT: A payment to a provider for services provided to a beneficiary resulting from the processing of a duplicate or near-duplicate claim by the contractor.

DUR: Drug Utilization Review.

E

EDI: Electronic Data Interchange. Standard format for exchanging business data. The standard is ANSI x12, which was developed by the data interchange standards association (DISA). ANSI x12 is either closely coordinated with or is being merged with an international standard, EDIFACT. Standards for EDI include: ANSI for claims, eligibility, enrollment, EBT, and remittance. CCIT for others. NCPDP for pharmacy, HEDIS for managed care.

EDIT: As applied to MMIS, an edit is a set of parameters against which a claim transaction is "edited." These edits can stop payment and/or generate reports. The verification and validation of claims data for detection of errors or potential error situations. Logic placed in the MMIS programming to cause claims that have specific errors to be placed in a suspend or deny mode due to not having successfully passed these edits.

EDMS: Electronic Document Management System.

EFT: Electronic Funds Transfer An electronic deposit system for provider remittance amounts, and the process of authorizing a computer system to transfer funds between accounts.

EHR: Electronic Health Records.

ELIGIBLE: Person who has been certified by the appropriate agency as meeting the criteria to qualify for Medicaid.

ELIGIBILITY FILE: A file that contains pertinent data for each Medicaid eligible individual enrolled in the Medicaid Program.

ENCOUNTER DATA: Information submitted to the MMIS by HMOs, PCP/CMs or other managed care organizations to describe service utilization by Medicaid beneficiaries.

ENCOUNTER RATE: A term used when Federally Qualified Health Centers (FQHC) and rural health clinic (RHC) providers bill and receive a rate (encounter rate) as opposed to a FFS reimbursement rate.

END USER: The ultimate consumer of an interChange product, especially the one for whom the product has been designed.

ENHANCE: Improve quality of software, hardware or other equipment.

ENROLLMENT BROKER: Contractor tasked with providing each Member and Potential Member with information about each CMO plan and assisting the Member in selecting a CMO plan and primary care provider that meets his/her family and individual health needs. This function will be included in the MMIS scope of work for this contract.

ENVELOPE: The combination of a header, trailer, and sometimes other control segments, that define the start and end of an individual EDI message.

EOB: Explanation of Benefits. A notice issued to the provider of Medicaid-covered services that explains the payment or non-payment of a specific claim processed for a member.

EOMB: Explanation of Medical Benefits. A notice issued to members selected at random listing all of the Medicaid services the member received the prior month. It instructs the case head to inform DCH if any services listed were not received and of any other problems.

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment. This term is used interchangeably with Health Check for the purposes of this RFP.

ESC: Error Status Code. Edit or audit assigned to indicate the error found on the suspended claim.

EXCEPTION: The phrase "posts an exception" is commonly used when discussing claims processing to indicate there is data on the claim that fails an edit; therefore, an exception is posted to the claim.

EXP: Expenditures. The issuance of checks, disbursement of cash, or electronic transfer of funds as reported by the state.

E

FACS CODING: Fund Source, FFP, and SCOA.

FBR: Federal Benefit Rate. The income limit used by SSA in determining SSI eligibility.

FEDERAL CERTIFICATION: The written acknowledgement from CMS that the operational MMIS meets the legal and operational requirements necessary for a percentage of Federal Financial Participation (FFP).

FEIN: Federal Employer Identification Number. Number assigned to a business entity for tax purposes. This number might be of value in identifying all the businesses owned by a corporation.

FFP: Federal Financial Participation. A percentage of State expenditures to be reimbursed by the federal government for medical assistance and for the administrative costs of the Medicaid Program. Federal Participation Percent which determines the funding split between state and federal funds. The period to use is based on Date of Payment.

FFS: Fee for service.

FIELD: An on-screen area used for entering specific information, such as a name or extension number, within the telephone system. A field prompt identifies the type of information that belongs in each field.

FIELD LEVEL PARAMETERS: Define each field on the claim form as being data or mark sense; establish X and Y coordinates where the date is found; set the field level readability requirements; determine whether the field is alpha, numeric or alphanumeric; and define the data validity editing to which the field will be subjected. (Imaging.)

FIELD VALIDATION: As each field is completed by the data entry operator, its validity is checked and the field is corrected, if necessary. (Imaging.)

FILE MAINTENANCE: The periodic updating of master files. For example, adding or deleting employees and customers, making address changes and changing product prices. It does not refer to daily transaction processing and batch processing.

FIREWALL: Security protection for a Web site (see proxy server), LAN, and Intranet. May check incoming and outgoing messages.

FIRM FIXED PRICE: A single price established by the awarding of this contract that is not subject to change or negotiation over the life of the contract.

FISCAL AGENT (FA): A contractor that processes for payment and adjudication, audits provider claims for payment, and performs other related functions, as required, as an agent of DCH.

FISCAL YEAR (FY): Federal - October 1 through September 30; State of Georgia - July 1 through June 30.

FLAT FILE: A database consisting of one table. It is a stand-alone data file that does not have any predefined linkages or pointers to locations of data in other files. This is the type of file used in a relational database; however, the term is often used to refer to a type of file that has no relational capability, which is exactly the opposite.

FORM LEVEL PARAMETERS: Establish the page size, ICN format, scanner control, image boost, dot matrix filter used, and acceptable readability. (Imaging.)

FPL: Federal Poverty Level. The minimum income required to support basic living costs for a family. The FPL is established yearly by the federal government and is based on the number of persons in a family.

FTE: Full Time Equivalent.

FTP: File Transfer Protocol. A method of transferring files between heterogeneous computing platforms. Since most large scale computing systems interface between mainframes, mini, PCs, and the Internet, a method is needed to transfer data between these different platforms. (See TCP/IP.)

FULL REFUND: Receipt received from a provider for the full amount of the original claim that was paid.

FUNCTIONAL ACKNOWLEDGEMENT: An EDI message that is sent in response to the receipt of an EDI message or packet of messages to notify the sender of the original message that it was received. It acknowledges only the receipt of the message or message packet, and does not imply agreement with or understanding of its content.

FUND SOURCE: The accounting interface codes used for federal and state funding based on the FFP determinations.

G

GAAP: Generally Accepted Accounting Principles.

GAAS: Generally Accepted Auditing Standards.

GAO: Federal Government Accountability Office.

GATEWAY: The interconnection between public or private networks that allow the transmission of documents in X12 format across multiple networks. Also called interconnect.

GB: Gigabyte.

GHF: Georgia Families. A Georgia program developed to deliver health care services to members of Medicaid and PeachCare for Kids™. The program is a partnership between the Department of Community Health and private care management organizations (CMOs).

GIS: Geographic Information System.

GMCF: Georgia Medical Care Foundation.

GO-LIVE DATE: Date on which application can be moved to a live environment after all testing has been successfully completed and written approval has been received from DCH.

GROSS LEVEL AR: Accounts Receivable transaction created on a payee that is not system generated based on net negative claim activity.

GROSS LEVEL PAYOUT: Payment made outside of the claims adjudication process and typically not linked to specific claims. HP Enterprise Services refers to as Expenditures.

GROSS LEVEL RECEIPT: Posting of a receipt against a payee number not linked to any AR or claim activity. Reduces 1099 balance but does not affect future payments.

GTA: Georgia Technology Authority.

GUI: Graphical User Interface. A "windows" based computer interface that allows for consistency of this application with other applications used by the operators. The device drivers associated with these GUIs optimize the painting of snippets and the rendering of fonts to take full advantage of the high-performance graphic cards installed in PCs.

H

HCBS: Home and Community-Based Services. HCBS includes waivered services for the elderly, disabled, mentally retarded/developmentally disabled, and physically handicapped.

HCPCS: HCFA Common Procedure Coding System. A coding system designed by HCFA (now CMS) that describes the physician and non-physician patient services covered by Medicaid and Medicare programs. It is used primarily to report reimbursable services rendered to patients.

HEALTH CHECK: Screening and immunization services, case management and continuing care services for children under 21 years of age, which are provided by a Medicaid provider approved as a screener. The services are reimbursed on a fee-for-service basis for private providers and on an encounter rate based on costs for clinic providers. EPSDT is used interchangeably with Health Check for the purposes of this RFP.

HEALTH CHECK CLAIM: A claim filed for payment of EPSDT Services. A claim is filed for screening or immunization services. The claim is filed on the CMS-1500 form.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law that includes requirements to protect the privacy of individually identifying health information in any format, including written or printed, oral and electronic, to protect the security of individually identifying health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

HIPP: Health Insurance Premium Payment. A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance.

HISTORY ONLY: The linking of a refund or a voided check to a claim that does not adjust the claim in such a way that it would affect a subsequent provider payment.

HOME HEALTH CLAIM: A claim filed for payment of Home Health Services. A claim is filed: (1) for one or more services given on the same date; (2) upon completion of services for a treatment period; or (3) at the end of a calendar month. The claim is filed on a CMS-1500 claim form.

HOME HEALTH SERVICES: These are provided in a home setting by a licensed home health agency that participates in the Medicaid Program. Services include but are not limited to skilled nursing, home heath aid, physical therapy, occupational therapy, and speech therapy. Reimbursement for covered services is based on reasonable cost as determined by cost reports and applicable costs of supplies and equipment.

HOST: Computer in which an application or database resides or to which a user is connected. Sometimes used generically as synonym for computer. (Imaging.)

HOT KEY: A term used to define the key used to request an imaged document to be retrieved. (Imaging.)

HYPERTEXT MARKUP LANGUAGE (HTML) : Programming language used to develop and maintain web pages on the Internet.

HYPERTEXT TRANSFER PROTOCOL SECURE (HTTPS) : Protocol to provide encrypted transmission of data between Web browsers and Web servers.

I

ICD-9-CM: International Classification of Diseases, 9th Revision Clinical Modification.

ICD-10-CM: International Classification of Diseases, 10th Revision Clinical Modification.

ICF/MR: Intermediate Care Facility for the Mentally Retarded.

ICF/MR CLAIM: A claim filed for payment of ICF/MR Services. A claim may be filed: (1) at the end of a calendar month; or (2) for the total period of confinement, if less than one month. The claim is currently filed on a UB-92 form.

ICF/MR SERVICES: Services provided in a licensed ICF/MR facility that participates in the Medicaid Program. The level of care is less than that received in a SNF. The per diem reimbursement is determined by cost report data.

ICN: Internal Control Number. Each claim is imprinted with an ICN in a sequential numbering order, beginning with the initial ICN keyed in the system by the scanner

operator. The ICN is printed across the top of the claim and is also written out to the OCR output record. The imaging system captures the ICN for indexing of the claim images and compiles a file containing all ICNs used to automatically update the control range of valid ICNs within the MMIS. A unique 13-digit identification number assigned to every GAMMIS claim in order to distinguish it from all other claims received by the system. The ICN consists of: two-byte Region, which represents claim media and claim type; a five-byte Date of Receipt, which consists of the YY – year and JJJ – Julian; and a six-byte Sequence number.

ICWP: Independent Care Waiver Program.

IMAGE: The computerized representation of a picture or graphic. (Imaging.)

IMAGE CAPTURE: The Kodak 990D scanner transportation carries the paper claim past the scanning array, which captures an image of the claim. This image is simultaneously sent to both the OCR subsystem and the CIRRUS imaging system.

IMAGING: A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.

IMPLEMENTATION GUIDE: A publication that identifies and defines the EDI messages used in a particular industry or application. The document indicates how the information in those messages should be presented on a segment by segment, and data element by data element basis, as well as identifying which segments and data elements are needed, which ones need not be used, and what code values will be expected in the application of that particular message.

INCENTIVES: A monetary or non-monetary motivator that is incorporated or result from the Contractor performance measures of the contract. These incentives influence the Contractor toward accomplishing the desired contractual outcomes.

INDIGENT CARE TRUST FUND (ICTF): The ICTF represents the largest component of DSH payments distributed through Georgia Medicaid. To participate in ICTF, a hospital must be a DSH provider. With ICTF funding, uninsured people who do not qualify for Medicaid may receive health care from participating hospitals.

INDUSTRY SPECIFIC: In EDI, it refers to the ability of an EDI Standard to be used by only one industry.

INITIATING CLERK ID: The ID of the clerk who initiated the claim adjustment online. The Financial system tracks this clerk ID as well as subsequent clerks who work on this adjustment by capturing and storing these IDs.

INPATIENT CARE: Care provided to a patient while institutionalized in an acute care facility.

INPATIENT HOSPITAL CLAIM: A claim filed for payment of Inpatient Hospital Services. A Claim may be filed: (1) for the total period of hospitalization; or (2) at some point during the hospitalization. The claim is currently filed on a UB-92 form.

INPATIENT HOSPITAL SERVICES: Services provided in a licensed hospital which participates in the Medicaid Program. Inpatient services are reimbursed based on a

hybrid-DRG prospective payment system. The majority of cases are reimbursed using a DRG per case rate. Remaining cases are paid based on a hospital-specific cost-to-charge ratio (CCR) system.

INQUIRY MODE: An window mode where the user is viewing data as the result of an inquiry rather than having accessed the specific window in order to add, change or delete data from certain financial records and/or claims. Inquiry Mode allows flow between the various parts of the system but does not allow changes to the data being viewed.

INSTITUTIONAL CARE: Medical care provided in a hospital or nursing home setting.

INTERNET PROTOCOL (IP) : Works like the postal system. There is no direct connection – just the packet address to send messages to, and the address for returned messages.

IRS: Internal Revenue Service.

ISDM: Information Systems Development Methodology.

ISP: Internet Service Provider. Commercial provider of Internet services; e.g., AOL, Bellsouth, ComCast, etc. To use the Internet a user must have a commercial ISP that maintains a computer system through which the user accesses the Internet.

ITF: Integrated Test Facility.

IVRS: Interactive Voice Response System. This is the machine and the application that enable users to access Georgia Medical Assistance Program information by using a touch-tone telephone.

IV&V: Independent Verification and Validation. The verification and validation of the design, development, and implementation (DDI) of the MMIS by an organization that is both technically and managerially separate from the organization responsible for developing the product.

J

JAD: Joint Application Design. Facilitated sessions between the Contractor and DCH users to ensure that the Contractor understands the State role, the Contractor role and the system requirements for each business area.

JCL: Job Control Language.

JOB QUEUE: A list of procedures in progress and procedures waiting to be run within the telephone system.

JOIN: A join defines explicit relationships between tables in a relational database. All other relationships are strictly implied. These joins enable users to relate the data in one table to data in another table in the same database so the user can query data from more than one table at a time. Tables are joined through columns.

JOIN PATHS: Join paths are the actual joins between tables in a relational database.

JOINT APPLICATION DESIGN (JAD) : The process where the system user and designer meet together to define the application. Generally, requirements are reviewed, validated, and clarified.

JULIAN DATE: The representation of month and day by a consecutive number starting with January 1. For example, February 1 is Julian 032. Dates are converted into Julian dates for calculation.

K

KEY: Keys are indexed columns in tables, often used to join tables. Keys uniquely identify each record, or row, in a table. Examples would be Cust-ID or provider number.

L

LAN: Local Area Network. A communications network that serves users within a confined geographical area. It is made up of servers, workstations, a network operating system and a communications link. Servers are high-speed machines that hold programs and data shared by all network users. The workstations, or clients, are the users' personal computers, which perform stand-alone processing and access the network servers as required.

LAW: Refers to constitutional provisions, statutes, common law, case law, administrative rules, regulations, and ordinances of the United States of America or the State of Georgia.

LIM Low Income Medicaid.

LIEN/WITHHOLD The taking of money from payment activity that does not reduce the payee 1099 balance.

LINE ITEM: A term used in reference to a level of detail on a claim. Line item details are services billed using a procedure code, a quantity, and a date of service for a specific fee. Claims may have multiple line items or detail lines.

LIQUIDATED DAMAGES: Payment made to the State for Contractor performance failures for which the actual cost or damage to the State cannot be determined or measured at the time of the failure.

LOC: Level of Care.

Long Term Care (LTC): Long-term care is the personal care and other related services provided on an extended basis to people who are clinically complex and may suffer from multiple acute or chronic conditions.

LTCF: Long-Term Care Facility.

LEVERAGED TECHNOLOGY GROUP (LTG) : The SE support group which processes the FDB DUR criteria update files, and passes the massaged updates on to the Interchange systems.

M

MAO: Medical Assistance Only. An eligibility group that receives assistance for medical services but does not receive money payment assistance.

MANUAL CHECKS: Checks written outside the automated check writing cycle.

MANUAL CLAIMS: Claims processed outside the automated claims cycle.

MANUAL RECOUPMENTS: Manual recoupments are non-claim-specific recoupments (financial reimbursements). These accounts receivable are manually set up by the State of Kansas to recoup money from providers.

MAPPING: The act of determining what pieces of information in the company's database should be placed into each data element of an EDI message or transaction set, or in reverse, what data elements of an EDI message or transaction set should be placed into the company's database.

MARS: Management and Administrative Reporting Subsystem. The MMIS subsystem that produces the management data required for financial, benefit, provider and member reporting.

MARTA: Metropolitan Atlanta Rapid Transit Authority.

MASS ADJUSTMENTS: The systematic adjustment of more than one claim at the same time for the same reason. Multiple adjustments entered at one time. Mass adjustments are requested on line and they are particularly useful when it is necessary to reprocess hundreds or thousands of claims. Mass adjustment requests are submitted for a specific population of claims. In other words, claims that have something in common. They may be all of the drug claims processed after a certain date, they may be a subset of claims for a specific provider, or they may be all of the claims processed for a specific beneficiary. The criterion for claims selection is highly variable.

MATERIAL COMPONENT(S) OF THE SYSTEM: A constituent element of the Medicaid Management Information System, or any of its ancillary systems, which is necessary for the system to function in accordance with the terms and requirements described in the RFP, the Contractor's proposal and this Contract.

MAXIMUS: Responsible for member enrollment in CMOs.

MEDICAID: The joint federal and State medical assistance program that is described in Title XIX of the Social Security Act.

MEDICAL REVIEW (MR) : Analysis of Medicaid claims to ensure that the service was necessary and appropriate.

MEDICARE: The federal medical assistance program that is described in Title XVIII of the Social Security Act.

MEDICARE CROSSOVER CLAIM: See "Crossover Claim."

MEDICARE PART A: Part A of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for hospital and hospital-related services. The formal designation is "Hospital Insurance Benefits for the Aged".

MEDICARE PART B: Part B of Title XVIII of the Social Security amendments of 1965 that provided benefits principally for physician's services. The formal designation is "Supplementary Medical Insurance Benefits for the Aged".

MEMBER: An individual eligible for medical assistance in accordance with a State's Medicaid Program or SCHIP Program (PeachCare for Kids™) and who has been certified as eligible by the appropriate agency and has received services.

MITA: Medicaid Information Technology Architecture.

MMIS: Medicaid Management Information System.

MSIS: Medicaid Statistical Information System commonly referred to as the automated submission of the CMS-2082 data to CMS.

MTD: Month to Date.

N

NAT: Nurse Aid Training.

NDM: Network Data Mover. A communications protocol for transferring data from one mainframe computer to another.

NET: Non-Emergency Transportation. NET Medicaid Program which through contractual agreements with brokers ensures the availability of non-emergency transportation to Medicaid-eligible persons who do not otherwise have access to transportation to medically necessary care.

NEW DAY CLAIM: Any claim, with or without attachments, received for payment consideration on that current business day. A claim is only considered "new day" on the initial date of receipt. Once the current day has passed, all unkeyed new day claims become part of the shelf inventory, which consists of all claims waiting to be processed.

NON-PROPRIETARY SOFTWARE: Any software or associated documentation that is not Proprietary Software

NPF: National Provider File.

NPI: National Provider Identifier as required by HIPAA.

NPP: Notice of Privacy Practices, as required by HIPAA.

NPS: National Provider System. An application system through which users have the capability to assign NPIs to providers and to access/update provider identification data. A voluntary federal and state joint venture to support CMS' Medicare Transaction System and to simplify program operations and provider transactions across programs. It will replace the existing Medicare Physician Identification and Eligibility System (MPIES) that currently issues the Medicare Unique Physician Identification Number (UPIN). Subsequently, new physicians would obtain a National Provider Identifier (NPI) rather than a UPIN number.

NSP: Network Service Provider. A company that maintains a network and offers its services and capabilities to others for a fee.

NTP: Non-Traditional Provider. Providers associated with a Georgia Families Managed Care Organization that are registered in the MMIS for informational reasons. The providers are not entitled to participate in the Georgia Medicaid/PeachCare for Kids™ fee-for-service program.

NURSING FACILITY SERVICES: Services provided in a facility that is licensed and regulated to provide nursing care services or intermediate care services for the mentally retarded and that participates in the Medicaid program. The per diem reimbursement is determined by cost report data, the level of care provided by the facility, and the case mix average score derived through the submission of resident assessments received from the nursing facilities electronically in a separate subsystem.

O

ONLINE: The use of a computer terminal to display computer data interactively. Available for immediate use. If your data is on disk attached to your computer, the data is online. If it is on a disk in your desk drawer, it is offline. Systems are designed as either online or batch. Online means terminals are connected to a central computer, and batch means entering batches of transactions on a second or third shift. Other terms, such as real-time and transaction processing evolved from online processing.

OPERATIONAL PHASE: The period of the contract that pertains to the day-to-day maintenance and operations of the MMIS and other functions as required.

OUTPATIENT CARE: Care provided to a patient in a non-institutionalized setting, such as a hospital outpatient clinic, emergency room, or other hospital based facility where room and board has not been provided.

OUTPATIENT HOSPITAL CLAIM: A claim filed for payment of Outpatient Hospital Services. A claim is filed: (1) for one or more services given on the same date; (2) upon completion of services for a treatment period; or (3) at the end of a calendar month. The claim is currently filed on UB-92 form.

OUTPATIENT HOSPITAL SERVICES: Services provided in a hospital emergency room or outpatient facility by a licensed hospital participating in the Medicaid program.

P

PA: Prior Approval.

PAID CLAIM: A claim that has resulted in the provider being reimbursed for some dollar amount. The amount may be less than the amount which the provider billed DCH.

PAID DATE: The date that a check or EFT was generated.

PANEL: A display screen of data, defined by a title and the tagged description of the objects, such as instruction lines, data entry lines, menu areas and command lines. Each of these objects may include other objects, described in the same syntax. Panel definitions are joined in a source file to form a panel group. Objects can be shared by all panels.

PARAMETER: Any value passed to a program by the user or by another program in order to customize the program for a particular purpose. A parameter may be anything; for example, a file name, a coordinate, a range of values, a money amount or a code of some kind. Parameters may be required as in parameter-driven software or they may be optional. Parameters are often entered as a series of values following the program name when the program is loaded.

PARTIAL REFUND: Receipt received from a provider for the portion of the amount of the original claim that was paid.

PASSWORD: Confidential code used in conjunction with the User ID to gain access to a system.

PATIENT INCOME: The patient's liability income amount that must be contributed toward the cost of nursing home care by each resident.

PATIENT LIABILITY: See Patient Income above.

PAYEE: The facility or person that receives payment.

PAYMENT CYCLE: A cycle from the adjudication of claims that results in payments to providers.

PAYOUT: Non-claim specific payment to a provider or other entity (i.e.: insurance company).

PBM: Pharmacy Benefits Manager.

PEACHCARE FOR KIDS (PCK) : PeachCare for Kids™. State of Georgia Children's Health Insurance Program (SCHIP). The federal-State Children's Health Insurance

Program (CHIP) was created under the Title XXI of the Social Security Act. The health benefits include primary, preventive, specialist, dental care, and vision care.

PEER REVIEW: An activity performed by a group or groups of practitioners or other providers to review the medical practices of their peers for conformance to generally accepted standards.

PENDING CLAIM: A claim that is in the adjudication process.

PER DIEM: A daily rate usually associated with payment to an institution such as a hospital or a skilled nursing facility assigned to institutional providers.

PHI: Protected Health Information. The information that needs to be protected that pertains to electronic, paper, or oral versions of information.

PHYSICIAN CLAIM: A claim filed for payment of Physician Services. A claim is filed: (1) for one or more services given on the same date, or (2) upon completion of services for a treatment. The claim is filed on CMS-1500 form.

PHYSICIAN SERVICES: Services provided by a licensed physician. Services include physician visits, laboratory and X-ray services, family planning, etc. Also included are professional services performed, certain optometry services, and eyeglasses as prescribed by a physician skilled in diseases of the eye or by an optometrist.

PI: Program Integrity Unit.

PIN: Personal Identification Number. A number used to provide a password into the system for security purposes.

PMBOK: Project Management Body of Knowledge. A guide to the current knowledge and common lexicon within the project management profession.

PM: Project Manager.

PMI: Project Management Institute.

PMO: Project Management Office.

PMP: Primary Medical Provider.

PMPM: Per Member Per Month.

POS: Point of Sale..

POS/EVS: Point of Sale/ Eligibility Verification System.

PRECERTIFICATION: Hospital precertification means approval of all inpatient hospital admissions (except routine deliveries) and selected services performed in an outpatient hospital or ambulatory surgical center setting at least one week prior to the planned admission or procedure. Emergent admissions and emergent surgical procedures must be certified within 30 calendar days of admission.

PREPAYMENT REVIEW: Provider claims suspended for review prior to final adjudication.

PRIOR AUTHORIZATION: An authorization granted by the State agency to a provider to render a given service to a specific member.

PROCESSED CLAIM: A claim that has been adjudicated.

PROGRAM: Used to reference ABD, LIM, or PCK.

PROJECT ID: Field that categorizes a transaction as Regular Medicaid/Family Planning, PeachCare, Breast and Cervical Cancer, Federal less state share, Money Follows the Person, and Refugee. Also combines transaction type as determined by the type of activity and the FFP period.

PROPRIETARY SOFTWARE: Any software and associated documentation provider to DCH and its Affiliates under this Agreement for which the Contractor or its licensors or any other third party retains any ownership rights or other Intellectual Property as authorized by 45 CFR Sect. 95.617 and for which no federal funds were used to design, develop, install or enhance such software.

PROTOCOL: In information technology, it is a set of rules describing the contents of an electronic communication. To communicate, both the sender and receiver must adhere to the protocol. See TCP/IP, HTTP, and FTP.

PROVIDER: An eligible institution, facility, agency, managed care organization, administrative service organization, person, partnership, corporation, or association as enrolled and approved by the State which accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules. Also, The renderer of a service to a member.

PROVIDER RELATIONS: Fiscal Agent employees that provide assistance to providers regarding Medicaid/MediKan programs.

PROVIDER ELECTRONIC SOLUTION (PES): Proprietary HP Enterprise Services software that allows providers to submit claims from a personal computer.

PRTF: Psychiatric Residential Treatment Facility.

PURGE: Refers to moving data from the master files to the archive files.

Q

QA: Quality Assurance.

QAT: Quality Assurance Team. A multi-disciplinary team that investigates, resolves, and monitors activities performed by the FA.

QI: Qualifying Individual; a "non-Medicaid" COA that provides only for payment of the recipient's monthly Part B Medicare premium.

QMB: Qualified Medicare Beneficiary. Aged, blind or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A&B), coinsurance and deductibles only.

QUEUE DIRECTORY: A directory on a hard drive into which batch requests to unit storage are placed. (Imaging.)

R

RA: Remittance Advice.

RAD: Requirements Analysis Document.

REALTIME SYSTEM: A computer system that responds to input signals fast enough to keep an operation moving at its required speed.

REASONABLE: To use appropriate instruments or methods to bring about a desired outcome which has been dictated by this contract or by the Georgia Department of Community Health.

RECORD: A set of related fields used to enter and store information in the telephone system. A table is a set of records.

RECOUPMENT: Money withheld from a provider's payment due to overpayment of claims during adjudication cycles. Recoupments may be established online by accessing the Accounts Receivable Set Up window. They may be set up as a percentage or as a set amount to be recouped. An Accounts Receivable record is established for each recoupment type a provider might have. The taking of money from payment activity and applying against an outstanding debt owed DCH. The activity reduces the payee 1099 balance.

REMITTANCE ADVICE: A record generated for Providers identifying payment(s) made to the Provider, the member(s) for which Medicaid made the payment(s), claims that have been entered into the system and are pending, and/or denied claims. The Remittance Advice is available hardcopy or electronic media at the discretion of the Provider.

RELATIONAL DATABASE: A database or collection of data organized into related tables comprised of rows and columns. The tables define relationships between the records.

RELEASE: The release is associated with a specific version of a product being made available to the client. Also known as system release or version.

RESOLUTION: Usually used in context as claims resolution, pending resolution, or suspense resolution. It refers to the process of working or correcting errors on a claim, forcing edits, updating or modifying inaccurate data such as a provider number or category of service, or any other activity necessary to complete the adjudication of the claim.

RESOURCE: Any real or personal property, stock, bond, or item of value owned by an individual.

REVENUE CODES: The three-digit accounting codes used on hospital claims to designate the service which generated the income, e.g., room and board = 110, laboratory pathology = 300, and physical therapy = 420. Revenue codes are used in billing both inpatient and outpatient services. These codes are essential to the hospital cost reporting process.

REVIEW: Examination and evaluation of the suitability of a particular deliverable or process.

RFP: Request for Proposals.

RTP: Return to Provider. Claims or non-claim documents that must be mailed back to the provider for additional information or clarity.

RULES BASED PROCESS: Rules Based Processing, or Table Driven System, or Parameter Based Processing are terms that refer to systems that store data element variables in user-alterable tables rather than storing them inside a fixed computer program.

RUN DATE: The date a report was generated.

RURAL HEALTH CLINIC: The RHC Program was established in 1977 to address inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. Rural Health Clinics are located in areas designated by the Bureau of Census as rural and by the Secretary of the Department of Health and Human Services or the State as medically underserved.

RURAL HEALTH CLINIC CLAIM: A claim filed for payment of Rural Health Clinic Services.

RURAL HEALTH CLINIC SERVICES: Services provided in a rural health clinic that participates in the Medicaid program. The services are reimbursed on a per clinic visit rate based on costs.

S

SAK: System Assigned Key.

SCALABILITY: The ability to manage the increases of staffing levels and of system throughput due to increased number of users, increased number of members, increased transaction volume, increased data volume and other relevant factors utilizing software and hardware modifications without impacting the performance of users.

SCAN: To convert human-readable images into bitmapped or ASCII machine-readable code. (Imaging.)

SCAN RATE: Number, measured in times per second, a scanner samples an image. (Imaging.)

SCANNER: A device that reads text, images and bar codes. Text and bar code scanners recognize printed fonts and bar codes and convert them into a digital code. Graphics scanners convert a printed image into a video image without recognizing the actual content of the text or pictures.

SCHIP: State Children's Health Insurance Program, in Georgia known as PeachCare for Kids. The Federal-State Children's Health Insurance Program (CHIP) was created under the new Title XXI of the Social Security Act. The health benefits include primary, preventive, specialist, dental care, vision care, impatient, and restorative.

SCOA: State Chart of Accounts. General Ledger account determined based on Date of Service.

SCREEN SCRAPING: The process of capturing data from a 3270 screen session, locating the image associated with that screen, and displaying it to the user. (Imaging.)

SDX: State Data Exchange. A file created by the Social Security Administration that contains all beneficiaries who are eligible for SSI, and other data pertinent to the eligible, including termination dates and changes to information on the record.

SERVICE: A covered medical benefit under the Medicaid Program performed by a provider for a member, usually indicated by a service or treatment code.

SERVICE ORIENTED ARCHITECTURE (SOA): Represents the processes and activities needed to manage the assets of the organization in their various states. Services are detailed in an organization's information model showing what information the "Service" owns (creates, updates, and deletes) and which information it references and is owned by other "Services".

SERVICE AUTHORIZATION: See Prior Authorization.

SKILLED NURSING HOME SERVICES: Skilled nursing home services are rendered in an institution to the member. The claim relating to skilled nursing home services represents the total period of confinement, if the confinement is less than one month in duration. If the confinement is longer than one calendar month in duration, a claim may be filed each calendar month.

SLC: System Life Cycle. The HP Enterprise Services methodology for the planning, development, implementation, and support of software system projects.

SLMB: Beneficiaries that are Specified Low-Income Medicare Beneficiaries who are eligible only for payment of their Medicare Part B premiums and whose income does not exceed 120 percent of FPL.

SNF: Skilled Nursing Facility.

SNF CLAIM: A claim filed for payment of SNF Services. The claim is filed on a UB92.

SNF SERVICES: Services provided in a licensed Skilled Nursing Facility (SNF) that participates in the Medicaid Program. The per diem reimbursement is determined by cost report data and the level of care provided by the facility case mix average score derived through the submission of resident assessments received from the nursing facilities electronically in a separate subsystem.

SOAP: Simple Object Access Patrol.

Provides a way for applications to communicate with each other over the Internet, independent of platform.

SORTING: Sorting allows the user to display the retrieved data in either ascending or descending order, or in alphabetical or numerical order.

SPENDDOWN : A type of Medicaid insurance deductible. The dollar amount of medical bills the beneficiary is responsible for taking care of before Medicaid can help the beneficiary pay his or her medical bills. Spenddown is the difference between the beneficiary's income and the Medicaid income limit. A qualifying county nurse may assign this dollar amount to a beneficiary (based on the beneficiary's income, etc.), which must be spent on medical needs prior to Medicaid benefits being available.

A process whereby an otherwise Medicaid-eligible person, but for excess income, may become eligible through obligation of the excess amount of incurred medical expenses. A requirement that certain beneficiaries, in order to be eligible for Medicaid, must spend money on their medical bills to offset their excess income. This is a requirement for the Medically Needy category of eligible beneficiaries. In cases of short-term spenddown, the spenddown amount is defined as being the amount that should be used for a beneficiary's provided services prior to Medicaid being involved.

SPSS: A commercial off-the-shelf statistics and data analysis software package.

SQL: System Query Language. The programming language used to access data in relational databases.

SSA: Social Security Administration. The federal agency that determines eligibility for SSI beneficiaries.

SSI: Supplemental Security Income. A federal needs-based, financial assistance program administered by SSA.

SSN: Social Security Number.

STAKEHOLDER: Party or parties that have a fiduciary interest in the Medicaid Management Information System (MMIS).

STORAGE CONFIGURATION: A drop-down list box containing these three options: Interactive, Batch, and User-Defined. (Imaging.)

SUBCONTRACTOR: Party contracting with the Contractor to perform services for DCH of not more than 30 percent of the total scope of services required under the contract. Entities which are subsidiaries or are otherwise owned in part or in whole by Contractor will not be considered subcontractors to the Contractor.

SUCCESS *(System for Uniform Calculation and Consolidation of Economic Support Services)***:** The Georgia system for determining Food Stamps, TANF, Social Services and Medicaid eligibility. Administered by the Department of Human Services (DHS),and the Department of Human Services Division of Family and Children Services (DFCS).

SURProfiler: The SUR process that provides a statistical screening tool designed primarily to identify physicians with medical resource use that is substantially different from their peers. It provides an in-depth view of utilization patterns and associated costs and allows for profiling of providers and members.

SURS: Surveillance and Utilization Review Subsystem of the MMIS.

SUSPENDED CLAIM: A claim that is taken from the processing flow for additional information, correction or review.

SYSTEM: All of the subsystems collectively and referred to as the MMIS.

SYSTEM CHANGE: A revision made to any portion of the subsystems collectively referred to as the MMIS for the purpose maintaining or improving the operation of the overall system.

SYSTEM GENERATED: Information not input from another source (e.g., a data file, data transmission or keyed by the user). Examples are date, time, calculated numbers, etc.

SYSTEM TEST: A test of all functions within a subsystem of the MMIS ensuring that all data and functions are handled correctly. In addition, the functions within the system are then tested to ensure interaction from system to system and outside the MMIS, i.e., BUY-IN, BENDEX, etc.

I

T-1 CONNECTION: A high-speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.

TANF: Temporary Assistance for Needy Families.

TCM: Targeted Case Management.

TDD: Telecommunication Devices for the Deaf.

TFAL: Technical Functional Area Lead.

TPL: Third Party Liability. A case in which an individual, institution, corporation, or public or private agency is liable to pay all or part of the medical costs of injury, disease or disability for a Medicaid member.

TIMEOUT: A state that occurs when a response is not given within a defined time limit, for example, when a caller is prompted to enter digits and does not do so

within the time period specified in the Voice System Parameters Table within the telephone system.

TITLE IV-D: Child and medical support services.

TITLE IV-E: Title of the Federal Social Security Act that authorizes financial assistance for foster children and for families receiving adoption assistance.

TITLE VI: Civil Rights.

TITLE XIX: The provisions of Title XIX of the Social Security Act, including any amendments thereto authorizing the Medicaid Program.

TITLE XXI: The Balanced Budget Act of 1997 amended Title XIX to provide each State the optional use of State child health assistance funds under Title XXI, State Children's Health Insurance Program (SCHIP) for enhanced Medicaid matching funds and expanded Medicaid eligibility for certain Medicaid groups.

TOC: Table of Contents.

Trading Partner: Entity that, by HIPAA compliance standards, can share information about a member.

TRANSACTION PROCESSING: Processing transactions as they are received by the computer. Also called online or real-time systems, transaction processing means that master files are updated as soon as transactions are entered at terminals or received over communications lines.

TRANSACTION SET: A block of information in EDI, making up a business transaction or part of a business transaction.

TRANSACTION SET STANDARDS: The system of syntax, data elements, segments, and transaction sets (messages) with which EDI will be conducted.

TRANSLATOR: A program used to convert information from flat file to EDI format or from EDI format to flat file.

TRUNK: A telephone line used to make and/or receive calls within the telephone system.

TRUNK GROUP: A set of trunks used for a specific application within the telephone system. Trunk groups are defined in the Trunk Group Database Table. Trunks are assigned to both an incoming trunk group and an outgoing trunk group in the Trunks Table.

U

UAT: User Acceptance Testing.

UB-04: The National Uniform Billing 04 form will replace the UB-92. Use of this form will be required beginning May 23, 2007.

UM/QIO: Utilization Management and Quality Improvement Organization (formerly known as PRO).

UPIN: Unique Physician Identification Number.

USER: A data processing system customer.

USER ID: The code unique to an individual which allows the user to sign-on to the computer system and defines the user's security status.

V

VACCINE FOR CHILDREN (VFC) : A federally funded program that provides immunization serum for qualified children.

VAN: Value-Added Network. A vendor of EDI data communications and translation services. (Switched network provider).

VPN: Virtual Private Network. Internet software for the client desktop. This allows two users to communicate via the Internet, and for security purposes, it is a closed network between the two sites. Along with this technique is "tunneling" which allows data to be sent through a private tunnel rather than over the Internet connection.

VSAM: Virtual Storage Access Method. An IBM access method for storing data, widely used in IBM mainframes.

W

WALKTHROUGH: Step-by-step review of a specification, usability feature or design conducted jointly by DCH and Contractor**.**

WBS: Work Breakdown Structure.

WHOLESALE CHANGES: Mass changes performed by computer program that detail how to process need standards and income increases for the designated group of beneficiaries covered by Medicaid.

WINDOWS: A graphics-based windows environment from Microsoft that integrates with and interacts with DOS. It provides a desktop environment similar to the Macintosh, in which applications are displayed in re-sizable, movable windows on screen.

WITHHOLD/LIEN: The taking of money from payment activity that does not reduce the payee 1099 balance.

WORFLOW Automates many of the manual activities associated with task notification, timing, escalation, completion and overall control. Workflow is engaged whenever there are desk to desk activities or sequential human interaction.

Example:

Item: Written Correspondence

Details of the written correspondence are stored within CTMS

Actual process of where the written correspondence goes is Workflow

WORK PLAN: A document describing in detail the activities required to complete a specific phase of the Contract, which clearly defines necessary tasks, participants, time estimates and schedules.

WIS: Waiver Information System.

WTD: Week to Date.

X

This section has no entries.

Y

YTD: Year to Date.

Z

This section has no entries.